ISSUES RELATED TO MEDICAL MALPRACTICE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

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ISSUES RELATED TO MEDICAL MALPRACTICE

THURSDAY, APRIL 26, 1990

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:35 a.m., in room 1100, Longworth House Office Building, Hon. William J. Coyne presiding.

[The press releases announcing the hearing follow:]

FOR IMMEDIATE RELEASE
THURSDAY, MARCH 29, 1990

PRESS RELEASE #25
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING ON
ISSUES RELATED TO MEDICAL MALPRACTICE

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on issues related to medical malpractice. The hearing will be held on Thursday, April 26, 1990, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark said: "The current malpractice system serves no one. The system costs too much, leaves some injured patients with no compensation, and fails to provide effective incentives to reduce the number of medical injuries. A comprehensive approach will require compromises from physicians, lawyers, patients and insurers to achieve the common objectives of lower costs, fewer injuries, and fairer compensation."

Witnesses will include The Honorable Charles Bowsher, Comptroller General of the United States, reporting on studies of medical malpractice conducted by the General Accounting Office.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

Malpractice claims involve physicians, attorneys, patients and insurers.

Physicians: In 1988, physicians paid $5 billion in premiums for malpractice insurance. While premiums have leveled off in recent years, they increased by as much as 20 percent per year in the early 1980's.

Premiums vary by locality and type of physician. Premiums are highest for obstetricians and neurosurgeons in Florida and Illinois; lowest for general practitioners in Arkansas.

About one-third of all physicians are sued at some point in their career. Fear of litigation has caused some physicians to do more tests and procedures, a practice known as defensive medicine. Defensive medicine raises the cost of health care, and increases risk to patients.

Attorneys: A significant share of the total cost of malpractice is spent resolving claims. Estimates range from 40 to 80 percent. That is, of the $5 billion paid in premiums in 1988, only $1 to $3 billion will be paid to injured patients; the rest is consumed by the legal and insurance systems.

(MORE)

Malpractice suits are generally resolved under State tort laws. Most States have enacted some type of tort reform in efforts to limit the increasing costs of malpractice. Research has shown that caps on awards, reductions in the statute of limitations and offsets to awards to reflect payments from collateral sources have had some impact on the growth in malpractice awards.

Patients: In 1984, the most recent year for which data is available, 30,000 injured patients received compensation totaling $2.6 billion. According to a recent study, these claims are only about six percent of the total number of injured patients. Medicare beneficiaries account for only 10 percent of claims. While most claims are resolved within two years, claims for severe injuries can take much longer. Compensation to injured Medicare and Medicaid patients tends to be lower than payments to privately insured patients.

Insurers: The malpractice insurance industry has experienced dramatic changes over the past 20 years.

The 1970's included a "crisis of availability" when some physicians couldn't buy coverage at any price. This led to the formation of new insurance companies, so-called physician mutuals, changes in underwriting practices, and enactment of some tort reforms by the States. The early 1980's included a "crisis of price" during which the cost of premiums increased at 20 percent or more per year.

Like most insurers, malpractice insurers are regulated by the States. While insurers generally pay more in losses than they earn in premiums, they earn net profits due to income from investment of their reserves funds.

Malpractice insurance is subject to the so-called insurance cycle, as evidenced by the periodic malpractice "crises" of the last two decades.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Thursday, May 10, 1990, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

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* * * CHANGE OF TIME * * *

FOR IMMEDIATE RELEASE
TUESDAY, APRIL 24, 1990

PRESS RELEASE #25-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A NEW TIME FOR THE HEARING ON ISSUES RELATED TO MEDICAL MALPRACTICE

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee's hearing on issues related to medical malpractice, originally scheduled for 10:00 a.m., Thursday, April 26, 1990, has been rescheduled for 10:30 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

All other details for the hearing remain the same. (See press release #25, dated March 29, 1990.)

* * * * *

Mr. COYNE. The committee will come to order.

Chairman Stark is going to be in another meeting on Capitol Hill and will not be with us here for the beginning of the hearing. But I would like to have unanimous consent to insert the chairman's opening statement in the record without objection.

[The statement of Chairman Stark follows:]

OPENING STATEMENT OF HON. PETE STARK

The current malpractice system fails to meet its basic objectives: providing fair and prompt compensation to injured patients at a reasonable cost.

Physicians, lawyers, patients and insurers are all responsible for the failure of this system.

The current malpractice system serves no one:

It doesn't stop malpractice, though it scares doctors into ordering more tests and doing more procedures.

Money that could be used to compensate more victims is consumed by the legal system.

It doesn't compensate most injured victims.

The insurance system protects physicians from the financial costs of their own negligence.

According to a study recently completed in New York State, nearly 2 out of every 100 hospital admissions by the elderly result in an injury due to medical negligence. Given this rate of negligent injuries, there are over 200,000 Medicare beneficiaries who will be victims of medical malpractice in 1990.

Most of these injuries are minor, resulting in minimal and temporary impairments.

However, for 32 percent of these cases, involving an estimated 64,000 Medicare patients, medical negligence will result in permanent disability or death.

While it may be argued that each of these patients deserves compensation, only a fraction of all injured patients, one out of eight, even file a malpractice claim.

Only 43 percent of patients filing claims ever receive any compensation. Those who are compensated must wait an average of 2 years before being paid. If the injury is serious, the victim must wait even longer.

While the victims wait for payment, the legal system consumes time and resources.

In 1984, $3.4 billion was spent to defend and pay out awards on malpractice claims. Nearly a quarter of that amount, $800 million was spent defending claims. An additional $600 million was paid to plaintiffs' attorneys.

Thus, over 40 percent of the total cost of malpractice is consumed by the legal system.

The uncertainties of the legal system—wide variations in the time to close a claim and wide variations in settlements—create problems for insurers. They pass the cost of this uncertainty on to their clients in the form of higher premiums. Even so, most insurers depend on investment income to show a profit.

While working under uncertainty, malpractice insurers also operate in a fairly unique market. In most States, one or at the most two insurers dominate the business.

Physicians can't shop for coverage. The cost of the so-called "tail policy" that is required when retiring or changing insurers precludes such behavior.

Uncertainty and lack of uniform underwriting policies give insurers substantial freedom in setting premiums and coverage limits.

There must be a better way.

Finding a better way will require the cooperation of the four parties to the system: doctors, lawyers, patients, and insurers.

Physicians must find ways to reduce the incidence of medical injuries. This might involve stricter medical discipline, tighter peer review, and remedial education for physicians whose performance is below par.

Lawyers will have to accept changes in the system for resolving claims. Injured patients deserve quicker and surer compensation for their injuries. The current system preserves the rights of a few, while ignoring the plight of the majority of injured patients.

Patients will have to accept that the malpractice system is not some lottery where, if lucky, they could hit the million dollar jackpot.

Insurers will have to provide greater assurance that their premiums are fair and appropriate.

I hope that today's hearing will be a first step toward finding a workable solution.

Mr. COYNE. We will proceed with the first panel of witnesses, the Honorable Charles Bowsher, Comptroller General of the United States; Lawrence Thompson, Assistant Comptroller General, Human Resources Division, and Susan Kladiva, Assistant Director, Human Resources Division.

At this point, I would like to recognize Mrs. Johnson from Connecticut for an opening statement.

Mrs. JOHNSON. Thank you very much, Mr. Chairman.

I just want to welcome everyone to this hearing and say how much I appreciate the thought that you and many others in our society are putting into this subject at this time.

I have made a proposal to begin to get something on the table because I feel very strongly that if we don't address the legal climate within which medicine is practiced today, we will not be able to deal with the larger issues that face us as we move toward the use of practice guidelines. And if, indeed, we want to have universal access to health care in the United States, we must be much more serious about addressing the cost drivers that are forcing the costs of health care ever upward ever more rapidly.

Malpractice reform, I think, is an essential building block for any change in our health care system to address today's pressing needs for universal access, to maintain quality and to prevent the erosion of access that has been typical of publicly funded health care systems.

So I appreciate your being here, and I look forward to the testimony today.

Thank you.

Mr. COYNE. Thank you.

Mr. Cardin.

Mr. COYNE. Mr. Bowsher.

STATEMENT OF HON. CHARLES A. BOWSHER, COMPTROLLER GENERAL OF THE UNITED STATES, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY LAWRENCE H. THOMPSON, ASSISTANT COMPTROLLER GENERAL, HUMAN RESOURCES DIVISION; SUSAN KLADIVA, ASSISTANT DIRECTOR, HUMAN RESOURCES DIVISION; AND NATWAR M. GANDHI, ASSISTANT DIRECTOR, TAX POLICY AND ADMINISTRATION ISSUES, GENERAL GOVERNMENT DIVISION

Mr. BOWSHER. Thank you very much, Mr. Chairman, and members of the subcommittee.

We appreciate the opportunity to present our views on the implications of medical malpractice for the establishment of future health policy.

As you are aware, the United States is spending over a half a trillion dollars each year on health care. More than 40 percent of it is publicly financed. Health care expenditures have grown from 6 percent of the gross national product in 1965 to about 12 percent today, and are projected to reach 15 percent in the next decade.

The precise extent to which medical malpractice has contributed to the rising health care bill is unknown. But there is little ques-

tion that the costs associated with it run into the billions of dollars. Of equal importance are the profound effects that medical malpractice is having on the way medicine is practiced in this country, effects that are likely to grow in the future.

In providing the leadership needed to deal with the malpractice problem, the Congress needs to address three primary issues:

How can we reduce the practice of negligent medicine?

Two, how can we improve the efficiency and the equity of our system for compensating victims of medical negligence?

And, three, how does the malpractice system affect the practice of medicine and the quality of care, and what is the outlook for the future?

We have summarized these, I might point out, Mr. Chairman, over here on one of the charts.

I would like to talk about each of these three areas in a few moments.

I would point out first, however, that malpractice is really more than a problem of costly insurance. During the last 20 years, the issue of medical malpractice has been defined largely in terms of the cost and the availability of malpractice insurance. These are but two aspects of a multidimensional problem.

The cost of medical malpractice insurance has increased from $1.7 billion in 1983 to $5.9 billion in 1988 for physicians, and from $800 million in 1983 to $1.3 billion in 1985 for hospitals. Although premium rates have recently been reduced somewhat, they remain only slightly below the historic highs.

Physician malpractice insurance premiums vary widely depending on the specialty involved and the physician's geographic location. For example, a neurosurgeon practicing in Chicago now pays almost $196,000 annually for the same coverage a colleague in North Carolina obtains for about $20,000. And I again have a chart over here that shows the differences by locality and by specialty.

Now, as we reported in 1987, the views of groups primarily affected by malpractice—consumers, attorneys, insurers, and health care providers—clearly show that the implications of the medical malpractice problem go well beyond insurance issues alone.

Consumers are concerned about the quality of medical care they are receiving and the long time required to settle malpractice claims. Attorneys believe that the large number of medical injuries due to negligence is the basic issue in discussions of malpractice. Insurers are concerned about the effects of the unpredictability of the tort system have on insurance ratemaking. And physicians and hospitals believe that malpractice insurance costs too much, patients' expectations are unrealistic, awards are excessive, claims take too long to settle, and legal costs to defend against the claims are too high.

Now, I would like to speak for just a minute on negligent medical practices which we feel must be addressed. The first area to be considered in any discussion of medical malpractice is how the incidence of medical negligence can be reduced.

A recent Harvard University study of medical malpractice in New York State indicates that, taken as a percentage of the number of 1984 hospital discharges, the rate of negligence by providers is 1 percent. While this may seem to be a small percentage,

it is significant when you are talking about the effects of medical injuries on individuals. In New York, it represents about 27,000 patients injured as a result of medical negligence.

Despite the relatively high number of physicians involved in claims paid to injured patients, few of the Nation's half a million practicing physicians have disciplinary measures taken against them. For example, in 1987, State boards took only 2,700 disciplinary actions against physicians, ranging from license revocations to reprimands. But before boards can impose sanctions against physicians, negligent actions or impaired performance must be reported to them. To date, many health care providers have been reluctant to speak out against their colleagues.

The Health Care Quality Improvement Act of 1986, and the Medicare and Medicaid Patient and Program Protection Act of 1987 represent recent legislative attempts to facilitate the identification and reporting of providers who are practicing substandard medicine. These legislative initiatives are a step in the right direction. But it remains to be seen whether they will improve the identification of providers delivering substandard care, and whether appropriate actions will be taken to deal with those providers.

Now, I would like to speak for a minute on the compensation system for victims of malpractice and the fact that it needs further refinement.

The system for compensating individuals injured through medical negligence is neither efficient nor equitable to those most directly affected by malpractice, namely the injured patients.

In our May 1987 report, we pointed out that it takes a long time for claims to be resolved and the cost of resolving them is high. For claims closed in 1984, it took an average of 25 months, with a range of up to 11 years from the date a claim was filed until final resolution. Insurers paid $800 million to investigate and defend claims closed in 1984 in addition to their total indemnity payments of $2.6 billion.

Finally, a large proportion of claim proceeds do not go to injured parties. In over half the claims closed in 1984, plaintiff legal fees exceeded 30 percent of the payments to the injured party.

Concerning the equity of our current system, studies have shown that only a small proportion of the injuries resulting from malpractice result in claims or suits. Harvard researchers have recently reported that only 1 of 8 patients admitted to New York hospitals in 1984 who suffered injury from negligence, filed a claim. Also, about 16 times as many patients suffered an injury from negligence as received compensation through the New York tort system. Thus, that system obviously does not reach many individuals who are injured by medical negligence.

Because of our concerns about the efficiency and equity of the system for resolving medical malpractice claims and compensating injured parties, we believe that it is time to take a harder look at the alternative ways to resolve malpractice compensation questions. There may be advantages to moving toward some form of system that would provide compensation to injured patients when specified events occur without having to establish provider negligence.

The next issue I would like to talk about is the fact that malpractice continues to affect the practice of medicine. It is clear that the high cost of malpractice insurance and the threat of litigation have contributed to significant changes in how providers deliver care to their patients. But views differ on the extent to which these changes improve the quality of medical services provided, decrease the incidence of negligent medical practice, or unnecessarily add to the cost of delivering health care.

Many activities are being carried out to help maintain and improve the quality of care. As these systems evolve and the information they generate becomes more available and understandable to the public, the performance of institutional and individual providers will be exposed to intense scrutiny. The implications of this for the future practice of medicine are not yet known. Also uncertain is the price the American public is willing to pay for the advances in quality expected to result from these systems.

Among the many activities being carried out to help assure the quality of health care are two that could be particularly helpful in reducing the potential for medical malpractice. One is the refinement of risk management activities, and the second is the development of practice guidelines.

Risk management programs were initiated in the 1970s to reduce the potential for medical malpractice in hospitals. They are used by hospital management to identify, assess, and reduce risks to patients.

Practice guidelines help physicians to determine how diseases, disorders, and other health conditions can most effectively be prevented, diagnosed, treated, and clinically managed. They can also help physicians improve service to patients, avoid unnecessary patient injury, and reduce the frequency of litigation.

Developments such as these are still evolving. Much remains to be done before it is known whether they are having the desired effects and are worth the added cost to the Nation's health care bill.

Mr. Chairman, as I indicated at the beginning of my testimony, the implications of medical malpractice are very far reaching. In our view, however, actions to deal with the malpractice insurance issue will not be enough to address the more fundamental issues of how best to, one, reduce the incidence of negligent care; two, fairly compensate individuals injured through medical negligence; and, three, deal with the complexities involved in efforts to enhance the overall quality of care provided in this country.

Both Government and the private sector actions to come to grips with these issues will have significant cost implications, and will help shape how medicine is practiced for years to come.

This concludes my opening statement, Mr. Chairman. We will be pleased to answer any questions. And if my full statement could be included in the record, we would appreciate that.

[The statement and attachment of Mr. Bowsher follow:]

STATEMENT OF CHARLES A. BOWSHER, COMPTROLLER GENERAL OF THE UNITED STATES, U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to present our views on the implications of medical malpractice for the establishment of future health policy.

As you are aware, the United States is spending over a half a trillion dollars each year on health care, more than 40 percent of it publicly financed. Health care expenditures have grown from 6 percent of the gross national product in 1965 to about 12 percent today and are projected to reach 15 percent in the next decade. These costs have risen at more than double the rate of general inflation for nearly three decades.

The precise extent to which medical malpractice has contributed to the burgeoning health care bill is unknown. But there is little question that the costs associated with it run into the billions of dollars. Of equal importance are the profound effects that medical malpractice is having on the way medicine is practiced in this country--effects that can be expected to grow in the future.

In providing the leadership needed to deal with the malpractice problem, the Congress needs to address three primary issues:

-- How can we reduce the practice of negligent medicine?

-- How can we improve the efficiency and equity of our system for compensating victims of medical negligence?

-- How does the malpractice system affect the practice of medicine and quality of care and what is the outlook for the future?

Our earlier extensive study of the medical malpractice problem, and work we have done since, show that these are difficult and complex issues. Efforts are underway to make improvements in each.

MALPRACTICE IS MORE THAN A PROBLEM OF COSTLY INSURANCE

During the last 20 years, the issue of medical malpractice has been defined largely in terms of the cost and availability of malpractice insurance. These are but two aspects of a multi-dimensional problem.

Medical malpractice was termed a crisis in the mid-1970s, when the premiums in some specialties rose several hundred percent in a single year and many insurers stopped selling malpractice insurance. The crisis was one of the affordability and availability of malpractice insurance for health care providers.

In response to that crisis, all states but one enacted legislation to address the problem. The emphasis was on measures to create alternative sources of insurance and to reduce the number and cost of claims. During this period, physician- and hospital-owned insurance companies were created to provide malpractice insurance. Over the next decade, malpractice insurance was more readily available in a market dominated by these companies.

Although the number and cost of malpractice claims continued to climb in the early to mid-1980s, insurance companies kept premium increases to a minimum because investments made at high interest rates were returning high yields. This changed, however, when interest rates began to decline in 1984. In response, insurers once again imposed large premium increases on

health care providers. This was labeled as a crisis of affordability of insurance.

The cost of medical malpractice insurance has increased from $1.7 billion in 1983 to $5.9 billion in 1988 for physicians and from $800 million in 1983 to $1.3 billion in 1985 for hospitals. Although premium rates have recently been reduced somewhat, they remain only slightly below their historical highs.

Physician malpractice insurance premiums vary widely depending on the specialty involved and the physician's geographic location. For example, a neurosurgeon practicing in Chicago now pays almost $196,000 annually for the same coverage a colleague in North Carolina obtains for about $20,000. (The attachment to my statement illustrates these variations in rates.) These premiums represent uniform rates paid by all physicians in a given medical specialty and defined geographical area. They are not based on an individual's own claims experience.

As we reported in 1987, the views of groups primarily affected by malpractice--consumers, attorneys, insurers, and health care providers--demonstrate that the implications of the medical malpractice problem go well beyond insurance issues alone. Consumers are concerned about the quality of medical care they are receiving and the long time required to settle malpractice claims. Attorneys believe that the large number of medical injuries due to negligence is the basic issue in discussions of malpractice. Insurers are concerned about the effects the unpredictability of the tort system has on insurance rate-making. Physicians and hospitals believe that malpractice insurance costs too much, patients' expectations are unrealistic, awards are excessive, claims take too long to settle, and legal costs to defend against claims are too high.

Mr. Chairman, all of the involved parties have expressed legitimate concerns about the malpractice problem from their own perspectives. We believe that these concerns, taken collectively, have public policy implications in at least the three areas I mentioned earlier.

NEGLIGENT MEDICAL PRACTICES MUST BE ADDRESSED

The first area to be considered in any discussion of medical malpractice is how the incidence of medical negligence can be reduced.

A recent study by Harvard University researchers of medical malpractice in the state of New York indicates that, taken as a percentage of the number of 1984 hospital discharges, the rate of negligence by providers is 1 percent.[1] This is consistent with the findings of the other major study of this subject, which involved an analysis of 1974 hospital admissions in California. While 1 percent may not appear to be large, it is significant when you are talking about the effects of medical injuries on individuals. In New York, it represented about 27,000 patients found to be injured as a result of medical negligence.

Our nationwide study of malpractice claims closed in 1984 showed that many physicians are involved in malpractice cases. In that year, 31,800 claims, involving 23,000 physicians, were closed with payments on behalf of injured patients. We recognize, of course, that a paid claim does not necessarily

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[1] Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York, A Report by the Harvard Medical Practice Study to the State of New York, Feb. 1990.

indicate the existence of medical malpractice or the need for disciplinary action.

Despite the relatively high number of physicians involved in claims paid to injured patients, few of the nation's 500,000 practicing physicians have disciplinary measures taken against them. For example, in 1987, state boards took only 2,700 disciplinary actions against physicians, ranging from license revocations to reprimands. These boards, which are responsible for imposing sanctions on physicians found to be incompetent or impaired by debilitating conditions such as alcoholism, drug abuse, or mental illness, are often criticized for not doing more. But, before they can impose sanctions against physicians, negligent actions or impaired performance must be reported to them. To date, many health care providers have been reluctant to speak out against their colleagues.

The Health Care Quality Improvement Act of 1986 and the Medicare and Medicaid Patient and Program Protection Act of 1987 represent recent legislative attempts to facilitate the identification and reporting of providers who are practicing substandard medicine. The centerpiece of the 1986 legislation is the National Practitioner Data Bank, which, when implemented, will contain information on disciplinary actions taken by state licensing boards, actions by hospitals and other institutions to deny or revoke clinical privileges, and medical malpractice claims paid by insurance companies that involve a licensed practitioner. Information contained in the data bank is expected to restrict providers' ability to move from state to state without discovery of their previous damaging or negligent performance. The act also seeks to facilitate the identification and reporting of incompetent practitioners by granting immunity from liability to individuals participating in peer review activities.

The data bank, originally scheduled for implementation in November 1987, was not funded until fiscal year 1989. It is now expected to be operational in September 1990.

The 1987 legislation authorized the Department of Health and Human Services to establish national exclusions from Medicare and Medicaid of practitioners who are excluded from either program, convicted of crimes involving federal or nonfederal programs, or disciplined by state licensing boards. The Department has decided to include data regarding state disciplinary licensure actions under this act in the aforementioned data bank.

These legislative initiatives are a step in the right direction, but it remains to be seen whether they will improve the identification of providers delivering substandard care and whether appropriate actions will be taken to deal with those providers.

THE COMPENSATION SYSTEM FOR VICTIMS OF MALPRACTICE NEEDS FURTHER REFINEMENT

The system for compensating individuals injured through medical negligence is neither efficient nor equitable to those most directly affected by malpractice--injured patients. In addition, it is questionable whether the system serves as a deterrent to the negligent practice of medicine.

Since the mid-1970s, every state has revised its tort system, in some way, to address the medical malpractice insurance problem. For the most part, these tort reforms have been designed to reduce the rate of increase in medical malpractice insurance premiums by reducing the number of claims filed and the size of malpractice awards and settlements. Studies have suggested that some of these tort reforms have achieved these

objectives. But the extent to which they have improved the efficiency of the system or increased the equity of payments to injured parties is unclear.

In our May 1987 report, we pointed out that it takes a long time for claims to be resolved and the cost of resolving them is high.[2] Our work showed that, for claims closed in 1984, it took an average of 25 months, with a range of up to 11 years, from the date a claim is filed until final resolution. We also found that insurers paid $800 million to investigate and defend claims closed in 1984. Such costs were in addition to the companies' total claim payments of $2.6 billion.

Finally, we found that a large proportion of claim proceeds do not go to injured parties. In over half the claims that were closed in 1984, plaintiff legal fees exceeded 30 percent of the payments to the injured party. In addition to attorney fees, plaintiffs were responsible for paying other expenses, such as court costs and the costs of obtaining evidence.

Concerning the equity of our current system, studies have shown that only a small proportion of the injuries resulting from malpractice result in claims or suits. Harvard researchers have corroborated the findings of previous research, which indicate that many claims are not being filed even though they may be justified. Specifically, the Harvard study pointed out that only 1 of 8 patients admitted to New York hospitals in 1984 who suffered injury from negligence filed a claim. About 16 times as many patients suffered an injury from negligence as received compensation through the New York tort system. Thus, the tort system obviously does not reach many individuals who are injured by medical negligence.

Questions have been raised as to whether the tort system provides an effective deterrent to malpractice. One of the system's fundamental objectives is to deter negligent behavior by requiring parties causing injury through negligence to pay damages to the injured victims. However, in regard to medical malpractice, health care providers' liability insurance may insulate them from most of the financial effects of their negligent behavior. Moreover, malpractice insurance companies do not generally vary rates based on an individual physician's claims experience, and most premium costs are ultimately borne by consumers, insurers, and the public sector. This further reduces the deterrent effect. However, we recognize that insulating physicians from the financial impact of their negligent medical care may not negate the deterrent value of the tort system. Insurance does not insulate them from the loss of reputation, personal morale, and practice earnings associated with defending themselves in malpractice litigation.

Because of our concerns about the efficiency and equity of the system for resolving medical malpractice claims and compensating injured parties, we believe that it is time to take a harder look at alternatives to the tort system as a means to resolve malpractice compensation questions. There may be advantages to moving toward some form of system that would provide compensation to injured patients when specified events occur without having to establish provider negligence.

There are many unresolved questions about the potential costs of alternative dispute-resolution mechanisms and whether they will do a better job of compensating individuals injured during medical diagnosis and treatment. Thus, we continue to believe--as we stated in our May 1987 report--that increased experimentation with these mechanisms is needed to see whether

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[2]Medical Malpractice: A Framework for Action (GAO/HRD-87-73, May 20, 1987).

they offer viable alternatives to the tort system as means of dealing with the medical malpractice problem.

MALPRACTICE CONTINUES TO AFFECT THE PRACTICE OF MEDICINE

It is clear that the high cost of malpractice insurance and the threat of litigation have contributed to significant changes in how providers deliver care to their patients. But views differ on the extent to which these changes improve the quality of medical services provided, decrease the incidence of negligent medical practice, or unnecessarily add to the cost of delivering health care.

Numerous activities are being carried out to help maintain and improve the quality of care. Intensified peer review of provider performance, establishment of increasingly sophisticated systems to measure the quality of care delivered by individual providers, and more arduous record keeping systems to document specific diagnostic and treatment actions have altered provider practices. As these systems evolve and the information they generate becomes more available and understandable to the public, the performance of institutional and individual providers will be exposed to intense scrutiny. The implications of this for the future practice of medicine are not yet known. Also uncertain is the price the American public is willing to pay for the advances in quality expected to result from these systems.

As the quality of care delivered by institutions and individuals has become more closely monitored, providers' practices have become increasingly defensive. Placing greater emphasis on not making mistakes, providers are performing additional tests and treatment procedures, giving more attention to increased medical record keeping, spending more time with patients explaining alternative treatments, obtaining patients' informed consent, and refusing to treat certain high-risk patients. Some of these actions may, in fact, be desirable. But when defensive medicine results in providers' performing unnecessary procedures or limiting services to high-risk individuals or underserved groups, the effect is undesirable.

The extent to which physicians practice defensively and the costs of such practices are unknown. The American Medical Association estimated that in 1985, costs associated with physician defensive medicine practices amounted to about $12 billion. Much higher estimates have been cited in both the general media and medical publications.

Among the many activities being carried out to help assure that the quality of health care remains high are two that could be particularly helpful in reducing the potential for medical malpractice--the refinement of risk management activities and the development of practice guidelines.

Risk management programs were initiated in the 1970s to reduce the potential for medical malpractice in hospitals. They are used by hospital management to identify, assess, and reduce risks to patients. Many organizations that deal directly or indirectly with hospitals believe that risk management helps reduce the incidence of malpractice and are taking an active role to either require or encourage the implementation of risk management programs or functions. These organizations include the Joint Commission on Accreditation of Healthcare Organizations, several states, insurance companies, and the Department of Health and Human Services. The American Medical Association, numerous medical specialty societies, and other elements of organized medicine are also involved in promoting the use of risk management in physician offices.

Practice guidelines assist physicians in determining how diseases, disorders, and other health conditions can most effectively be prevented, diagnosed, treated, and clinically managed. They can also assist physicians in their efforts to improve service to patients, avoid unnecessary patient injury, and reduce the frequency of litigation. The American College of Physicians has been a strong proponent of their development and, along with other advocates, believes that their use has resulted in fewer malpractice claims and lower insurance premiums. Developing these guidelines is a complex process that requires considerable consensus building among practitioners within individual medical specialties. It will be some time before their full impact can be assessed.

Developments such as those I have described are still evolving, and how they will unfold is far from certain. Much remains to be done before it is known whether they are having the desired effects and are worth the costs they will add to the nation's health care bill.

CONCLUSION

Mr. Chairman, as I indicated at the beginning of my testimony, the implications of medical malpractice are far reaching. If the availability and affordability of malpractice insurance again becomes a major problem, the Congress and state legislatures can expect to be petitioned again to take remedial actions.

In our view, however, these actions will not be enough to address the more fundamental issues of how best to (1) reduce the incidence of negligent care, (2) fairly compensate individuals injured through medical negligence, and (3) deal with the complexities involved in efforts to enhance the overall quality of care provided in this country. Both government and private sector actions to come to grips with these issues will have significant cost implications and will undoubtedly help shape how medicine is practiced for years to come.

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This concludes my prepared statement. We will be pleased to respond to your questions.

ATTACHMENT

MALPRACTICE INSURANCE PREMIUMS
ST. PAUL INSURANCE COMPANY
FOR SELECTED SPECIALTIES, AREAS, AND YEARS[a]

	1984	1985	1986	1987	1988	1989
Obstetrics:						
Chicago	$39,820	$56,810	$95,000	$168,100	$156,580	$155,510
Minnesota	19,240	27,580	37,990	49,280	57,130	42,330
North Carolina	9,290	12,810	15,290	19,440	20,620	16,270
Neurosurgery:						
Chicago	59,500	71,830	120,110	212,830	197,330	195,950
Minnesota	28,690	34,850	48,000	62,270	71,870	53,290
North Carolina	13,790	16,120	19,240	24,500	25,900	20,400
General practice (No surgery):						
Chicago	5,350	7,010	11,850	20,660	20,110	20,050
Minnesota	2,650	3,510	4,940	6,320	7,560	5,720
North Carolina	1,370	1,733	2,100	2,620	2,900	2,350

[a]Premiums shown are for coverage of $1 million per occurrence and $1 million in aggregate for a policy year.

Mr. COYNE. Thank you very much, Mr. Bowsher.

Could you explain why there are huge variations among the States in premiums, claims filed, and awards?

Mr. BOWSHER. Well, I think you have several factors involved. You have the fact that the legal profession is more represented I think in some of your larger cities and you have different court systems.

You also have a different attitude you might say, in some parts of the country about whether to sue or not to sue.

Also, of course, I think the quality of care varies across the country. So there are many different factors that come into play here.

Mr. COYNE. Have any of the tort reforms had any measurable effects in your judgment?

Mr. BOWSHER. We think that some of them have. I would like to have Larry Thompson, who has worked on these studies and Sue Kladiva who is with me today add to my response.

But we think that in some of the States you have seen some changes, and these, I think, should be watched very carefully.

Mr. COYNE. Would you be able to cite the reforms that have been effective?

Mr. THOMPSON. Those that seem to have had an effect include elimination of the collateral source which precluded the defendant from informing the jury that the plaintiff had already received other compensation resulting from injury. Now, if an injured individual has received compensation from another source, that fact is either made known to the jury, or may be automatically deducted from an award. So a plaintiff can't be compensated twice.

Changes to shorten the statute of limitations for filing claims so that an injured party can't wait forever to file and some form of cap. The amount of award for noneconomic losses such as pain and suffering seem to have worked.

There is some evidence that arbitration panels have had the effect of reducing the average size of the awards, although they may also increase the number of people who file. This may help address the problem of so many people being injured and not actually being compensated. The arbitration panel gives access to the system to more people, so it increases the number who get compensated, and reduces somewhat the average size of the award.

Those are the ones that I think are generally thought of now as of having had a substantial effect.

Mr. COYNE. If the tort system doesn't deter medical negligence, what would or what could deter it?

Mr. THOMPSON. I'm not sure how you are going to decide frankly at the end whether the tort system has had a deterrent on the practice of negligent medicine. I think the evidence is that it has had some impact, not on individual physicians as much as by heightening the awareness of the whole system to the need to be more conscious about quality assurance and quality control and dealing with risks and incidents of negligence.

So the expenses of malpractice insurance cause hospitals to be receptive to changes in the way they do business and make them more conscious and better able to deal with quality of care issues.

It is hard to separate the incidence of negligent care from the whole issue of how to improve the quality of care. And so I would

say that many of the initiatives which the Government and the private sector have underway, initiatives designed to improve the quality of care, should also help address the negligent care problem. And the one, of course, that is currently attracting the most attention is the practice guidelines initiative.

There is some evidence among anesthesiologists that where some practice guidelines were introduced, the incidence of malpractice claims dropped rather dramatically. Now, that may be the most dramatic example we will ever have, but it is an example where practice guidelines respect a systematic attempt to codify what is the right thing to do in a given situation and thereby serve to reduce the amount of negligence.

Mr. COYNE. Do you have any evidence that suggests whether Medicare beneficiaries are disadvantaged under the present tort system?

Mr. BOWSHER. Yes. I think the statistics do show that their awards generally run a little less than some of the others. Larry, what are the exact numbers.

Mr. THOMPSON. Our numbers from the closed claims in 1984 show that when we divided the average award by the source of the payment for the service, Medicare beneficiaries on average were awarded $28,000. The global average was $80,000.

Mr. COYNE. $8,000.

Mr. THOMPSON. $80,000.

Mr. COYNE. $80,000.

Mr. THOMPSON. Yes.

Mr. COYNE. Thank you very much.

Mrs. Johnson.

Mrs. JOHNSON. Thank you very much, Mr. Chairman.

Following up on the previously asked question in regard to the equity of the current system for seniors, it seems to me that the New York study makes a very strong case that the current system specifically disadvantages seniors because under it, even where there is good evidence that there has been malpractice, they are not suing in much larger numbers than any other group.

Do I read that study correctly?

Mr. BOWSHER. Yes, do. No question about it. And I think the other research studies have indicated very similar situations, that the senior people generally don't sue as often, and when they do get settlements, their settlements generally are less than what some of the others are.

Mrs. JOHNSON. The fact that our system takes a long time to resolve a claim, and that resolving a claim can be very costly and a great mental burden over all those years, all work against the seniors suing.

One thing that has truly surprised me in my work in this area in the last few months is the degree to which our system really stridently disadvantages seniors in America.

I want to tell you how pleased I am that you are here today. I know, on behalf of the Energy and Commerce Committee and other members, you have been involved in research into malpractice issues for several years now, and really have a substantial body of work accumulated in this area that will be very helpful to us.

But do you have any evidence that the availability of arbitration actually does increase access?

Mr. BOWSHER. Sue, why don't you take that?

Ms. KLADIVA. The studies that Mr. Thompson referred to on arbitration increasing the frequency of claims, but reducing the severity, was an econometric study. So I think it is a clear demonstration that it does have an effect.

We found in our study that it is very difficult for individuals with small claims to enter the tort system. Although one of the advantages that is alleged of the tort system is that because of the contingency fee basis, it gives people access who otherwise would not be able, through their own financial resources to obtain legal representation. But it also acts as a barrier because of the cost of bringing claims. Small claims are still disadvantaged in getting into the litigation system. Arbitration does appear to remove that barrier.

Mrs. JOHNSON. Thank you. That's a very interesting and very important point.

You mentioned some of the ways in which State actions have tended to reduce costs. It is my understanding that while there was a lag of a number of years, that in California, which has adopted most of the reforms that you mentioned there is an appreciable difference between their liability premiums and those of other States that haven't adopted tort reform.

Mr. THOMPSON. That is our understanding, yes.

Mrs. JOHNSON. One other thing that I wanted to hear you discuss at a little greater length.

On page 11 of your testimony, you talk about both the pros and cons of the threat of litigation. And I think that is very important to bring out. The threat of litigation has forced greater scrutiny of medical practice, and has, in certain ways, improved the quality of practice. And yet we are all aware of the unnecessary costs that it seems to be adding by way of defensive medical practices.

In your research, have you come to any conclusions about how we could improve our ability to identify negligent practices or weak practitioners early and, thereby, improve how we identify problems and take disciplinary actions, without preserving a system that imposes extraordinary costs and rewards the most excessive kind of care?

Mr. BOWSHER. We have not done that research, Ms. Johnson. I think it is an important issue, and I think some other people have looked at it. But GAO has not done that research and, therefore, we don't really have a good answer for you.

Mrs. JOHNSON. Well, thank you. We will probably be talking to you about that again in the future.

Thank you, Mr. Chairman.

Mr. COYNE. Mr. Pickle.

Mr. PICKLE. Mr. Chairman, thank you.

Mr. Bowsher, I was not here to hear all the testimony of you and this panel. But I have looked over some of your testimony.

May I ask you if your group has testified in favor of the bill that Mrs. Johnson has introduced? Do you recommend that, or do you take any position on it?

Mr. BOWSHER. We have not taken any position on that bill.

Mr. PICKLE. Well, I believe you said that Congress ought to experiment with an alternative system. And I take that to mean that you recommend that we try to find some approach similar to that if we can.

Now, that would have reference to the area of compensation I presume. Chairman Coyne had asked you about what other areas, such as the quality of care or in the area of negligence. Do you have any recommendation in those areas?

Mr. THOMPSON. In response to your first question, Mr. Pickle, we have taken the view that the Congress and the Federal Government ought to encourage State experimentation. This is an area where the laboratory of the States is particularly appropriate——

Mr. PICKLE. I can't hear you. I'm sorry.

Mr. THOMPSON. We have taken the position to urge the Congress and the Federal Government to encourage the States to experiment in this area, to try different tort reforms or different alternatives to the tort system. It is a very complicated area, and I don't think anybody studying it can come up with a solution that is such a sure fire solution that we ought to just adopt it nationwide.

I think the kinds of proposals that Mrs. Johnson has put forward do constitute one of the types that ought to be looked at.

Mr. PICKLE. Well, have you made any analysis of State tort reform programs in the various States in this field.

Mr. THOMPSON. Yes, sir, we have.

Mr. PICKLE. Have you submitted to our committee an analysis of the various States and their status?

Mr. THOMPSON. Yes, sir. We published that report about 2 years ago.

Mr. PICKLE. Have you? I have not seen it, but you have made that report.

Mr. THOMPSON. We will be happy to get you a copy of that report. In it we outline what reforms have been adopted, in which States, and what people know about the effectiveness of those reforms.

Mr. PICKLE. Well, I'll be anxious to look at that report but I have not seen it.

Can you tell me whether the States are making improvements or have suggested alternative approaches in this field?

Mr. THOMPSON. Yes, sir. In the last 15 years, I think all States but one have done something in terms of modifying their tort system one way or another.

Now, there is just a tremendous variety of changes that have been made.

Mr. PICKLE. Has my State of Texas made some specific improvements, or passed legislation in this field?

Mr. THOMPSON. I think so.

Mr. PICKLE. I am just wondering what they have done, if anything. And I don't intend to try to just trot Texas out for a close examination. It is just the reason I asked that question.

My Subcommittee on Oversight, about 2 years ago, 3 years ago now, held an exhaustive series of hearings on the tort liability question.

We found that most of the States are just looking at the tort liabilities issue and thinking about it, and said that's a problem. And

nothing was really being done on either a Federal, State or local basis. Everybody just viewed it with concern.

Now, if the States made some improvements all across the land I would like to know what they were and what approaches have actually been accomplished, if any.

Mr. Bowsher, do you have any comment on the status——

Mr. BOWSHER. Why don't I let Larry do it because he has been working on this issue.

Mr. THOMPSON. Yes, Texas has made some changes and we would be happy to supply more detail for the record. The changes include establishing penalties for people who enter frivolous lawsuits and modification of the joint and several liability rule. They have also made a change which precludes a plaintiff from announcing how much he/she is asking for at the time the lawsuit is filed.

These are some of the changes. Now, they have not made as many changes as some of the other States have, but they have made some. We would be happy to give you a chart showing State tort reforms.

Mr. PICKLE. When we had our hearings previously, Mr. Nat Gandhi had conducted a survey for our subcommittee. And I think he is here.

Mr. THOMPSON. Yes, he is.

Mr. PICKLE. Is he here now?

Mr. GANDHI. Yes, sir.

Mr. PICKLE. Mr. Gandhi, let me ask you. Would you mind him coming up here?

Mr. BOWSHER. Fine.

Mr. PICKLE. Can you try to give us some kind of a summarization of the findings of your work in the field of medical malpractice?

Mr. GANDHI. Yes, sir. What we had worked on was focused on the profitability of the insurance industry in general, and medical malpractice in particular.

What we had discovered in summary in terms of the profitability of the insurance industry is that its profitability is, on an average, at par with other industries such as banking, utilities and transportation in terms of rates of return.

In an area, such as medical malpractice, and also in the automobile insurance industry, they do have some problems about the profitability.

The other problem that we had identified was that the profitability of the insurance industry is primarily cyclical in nature. Every few years, they experience a crisis of availability and affordability of insurance. But, in general—and this profitability has been on an average, at par with other industries.

Mr. PICKLE. I recall that we found a few years ago that some of the insurance companies were charging higher premiums without any additional compensation to be allowed.

Has that problem been addressed?

Mr. GANDHI. Well, sir, if you look in terms of the numbers of the dollars, the profits have been huge. For example, from 1975 through 1985, the medical malpractice lines of the insurance industry earned about $2.1 billion if you were to discount their reserves.

However, we have to look at the profitability in terms of the rates of returns. And when you look at the rates of return, the

medical malpractice line had earned about $15 on every $100 of premium.

Now, there is a big controversy about that primarily in two ways. One is that the reserves that are included in computation of these numbers, should they be discounted or not? In other words, would you take into account the time value of money?

The second caution is about the adequacy of these reserves, whether or not the reserves that are put aside by the insurance companies are adequate. At that time, the insurance industry had contended that the reserves are not adequate. We need to put more in reserves.

If you want more reserves, then the profitability goes down.

Mr. PICKLE. Well, I want to look into these findings more as we go along. And I am trying to ask myself, is there any connection between the compensation of the tort laws with recertification? Do you tie them together, any of you, any of the panelists? Is there any close relationship other than just a general association, or do you think the answer to this lies in recertification of physicians?

Mr. BOWSHER. I do not think that we in our work, Mr. Congressman, have been able to make that tie.

Mr. PICKLE. All right. Thank you, Mr. Chairman.

Mrs. JOHNSON. Would the gentleman yield?

Mr. PICKLE. I yield, yes.

Mrs. JOHNSON. On your issue of profitability, what I heard you saying was that the dispute about profitability hinges primarily on the dispute about reserves. And the dispute about reserves hinges on whether or not the claims in the future are going to be greater or less than predicted/

Mr. GANDHI. Yes.

Mrs. JOHNSON. Is that correct and is that why it is so difficult to analyze?

Mr. GANDHI. Yes.

Now, in those States where they have capped awards, they have a greater ability to determine what the outyear costs might be and, therefore, can more accurately determine what reserves are necessary and determine profitability.

Mrs. JOHNSON. Is that part of the reason why premiums tend to be lower in those States that have included caps in their tort reform process than those States that have not?

Mr. GANDHI. Well, we have not studied this issue of profitability in the last 2 years. I think the major changes that have happened about the caps, et cetera, have been of recent origin.

Mrs. JOHNSON. Yes.

Mr. GANDHI. So it would be difficult for me to answer that.

But let me put it generally this way, Mrs. Johnson, that not only in terms of the adequacy of the reserves, but it is also in terms of the time value of money. For example, if you need to pay $10 up to 10 years, what amount of reserves should you put aside now? The insurance industry in general had been putting aside, before the Tax Reform Act, the entire amount of $10 rather than accounting for the time value of money and providing discounted reserves.

Mrs. JOHNSON. Thank you. Thank you, Mr. Chairman.

Mr. COYNE. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

In this committee, we hear a lot about what is happening in other medical systems around the world in this area.

I am wondering whether you have any information for us as to whether there are any comparable systems in nations, and what has happened in those nations as it relates to the professional liability issue and compensation issues?

Mr. BOWSHER. I think you have a very important point there, Mr. Congressman. And we are currently looking at some of the other systems, especially a system like Canada where they have considerably less medical malpractice.

Now, there is no question that they have a different system, and that is one of the reasons why they have less medical malpractice. But much of their system is similar to ours. In other words, we think there are some similarities. And I go back to what Mrs. Johnson said in her opening statement about these very high rising costs. In other words, our health care system in this country the cost trend is about double what the inflation rate is, considerably more than that is other Western countries are.

And as we face greater competition here in this post-cold war period with Europe and Asia, and I think it is the health care area that we have to spend a fair amount of time trying to figure out how to have a system that gives us good coverage, good health care, and does not quite have the upward cost trend that we have had here in recent years. And the medical malpractice is one of those important issues that we have to look at. And I think we should look outside our country at some of these other systems, particularly the ones, as you point out, that have some similarities to our system.

I do not think you can take somebody else's system and just move it to the United States, but I think we should be studying some of those features.

Mr. CARDIN. It seems to me that in some of these other countries, they really have not imposed changes in their tort systems, but yet the comparable premiums for professional liability are a lot less, and the compensation system appears to be a lot quicker.

Of course, our legal system has not been copied any other place in the world. We are unique in that regard.

Mr. BOWSHER. Right. And the number of lawyers we have is kind of unique too. [Laughter.]

Mr. CARDIN. Thank you, Mr. Chairman.

Mr. COYNE. Mr. Moody.

Mr. MOODY. Thank you. I noticed that a number of States have in fact enacted some form of tort reform or medical malpractice reform on a State-by-State basis. But it varies tremendously as to just how they have done it.

Did you or do you know of anyone else who has compared the types of malpractice reform to the change in malpractice costs? In other words, could you set up a multivaried equation and find out what the partial impacts are, the different institutional changes?

Mr. THOMPSON. Yes. We have taken a look at that, and several private sector researchers have also looked at it.

The consensus right now is that there is two or three of those changes which do appear consistently to have had an effect on the premiums. And the three that appear most consistently to have an

effect are what is called the collateral source rule. That is where you are allowed to tell the jury that the injured patient will be compensated through some other system or, alternatively, in some of the versions you simply deduct what compensation would come from other systems, from whatever settlement there is as a result of malpractice. So that is one of them.

Another one is changes in the statute of limitations. Sometimes the statute of limitations has been quite long. And this is especially important in infants' situations where in many States it was common, that the statute did not even begin to run until the infant reached age 21. So that a 3-year statute of limitations became a 24-year statute of limitations.

Mr. MOODY. Therefore, there was a very long tail on the risk.

Mr. THOMPSON. A very long tail, right. Which made the insurance companies, of course, very apprehensive about writing a policy may result in a claim 24 years later.

And the third element that appears to have had an effect are various caps on the size of awards, usually on noneconomic awards, pain and suffering. I think they are most commonly a dollar limit. Maybe a quarter of a million or a half a million dollar ceiling.

Mr. MOODY. So of all the institutional or legislative changes, those three seemed to have a greater impact on the premium cost.

Mr. THOMPSON. That is right.

Now, other research has shown that arbitration panels may not affect the premium costs, but they do tend to reduce the size of awards but they also tend to increase the number of claims that are filed. So they may make the system more equitable in that people who have relatively small claims are able to file them. That is sort of a good thing from the equity standpoint but it may not save any money.

Mr. MOODY. Right. Well, the testimony of the GAO is that we have to do a number of things, cost is only factor in a more equitable system—including reducing delays to resolution.

What about other forms of equity for the patients themselves or for injured parties? If you make that your outcome variable and you regress these other changes, you site the three for premium costs, for example, what else do you do?

Does changing the statute of limitations speed up anything? Probably not, but how about changing the caps on the size of awards. Would that make the insurance companies more or less apt to settle quickly?

Mr. THOMPSON. I do not think anybody really has studied that, or I am not aware of any studies that have begun to get into the detail that you are asking about now. Those are good questions you have.

Mr. MOODY. Well, it seems to me if our goal is (*a*) to reduce cost and, (*b*), to make the system better for patients who in fact have a legitimate claim of some size, then we need to look at several things.

If you come across a study like that, I would appreciate hearing about it.

Can I go back to Mr. Pickle's question about reserves?

If you used discounted value calculation, which you must do to have any intelligible answer, what is the answer? Can you try it again assuming you do use those calculations?

Mr. GANDHI. Sir, if you do discount the reserves, then, of course, the profitability is substantial, and we look in terms of total numbers. Let me just look at those numbers again.

We studied the medical malpractice line of the insurance industry from 1975 through 1985. If you discount the reserves——

Mr. MOODY. Right. You mean discount for time value of money?

Mr. GANDHI. Yes, sir.

Mr. MOODY. Right.

Mr. GANDHI. The profits are about $2.1 billion. Now, if you do not discount the reserves, which is what the States required you to do, that is you do not discount the reserves for State regulatory purposes, then you have a loss of about $615 million.

Mr. MOODY. Right. But if you do it as any intelligent calculation should and count time value of money, then you get a profit of $2.1 billion.

Mr. GANDHI. Right. But now let me—may I interrupt you, sir? And indicate that we also have to look at the rates of return rather than the——

Mr. MOODY. Well, I was going to say the amount of profit is important is what is the rate of return on invested capital?

Mr. GANDHI. Now, we do not have the rate of return on invested capital. But we do have it on premium dollars. That for each $100 of premium in medical malpractice line, if you discount reserves, that rate is about $15.

Mr. MOODY. $15. So then every——

Mr. GANDHI. Now, may I also further qualify, sir, that if you think that the reserves are inadequate, say by 10 percent, then that 15 goes down to about 13. And if you think the reserves are not adequate by 20 percent, then that rate goes down to about 11.

Mr. MOODY. OK. Let's take 13, intermediate position.

Mr. GANDHI. Yes, sir.

Mr. MOODY. $13 per hundred hours of revenue is much higher, much more than a 13 percent rate of profit on invested capital. I mean usually you do not count profitability of a firm relative to revenue, but based on investment.

Mr. GANDHI. Yes, sir. But there are measurement problems. And the measurement problem here is that it is difficult to isolate what is the invested amount in terms of just the medical malpractice line. Because these companies are multiline companies.

Mr. MOODY. But $100 of revenue takes a far smaller amount than $100 of investment to produce. I mean revenue is a flow-through——

Mr. GANDHI. Yes.

Mr. MOODY [continuing]. As opposed to that initial investment. I mean I open a company, and my investment is going to be a lot smaller than my annual revenue presumably, right?

Mr. GANDHI. Yes, sir.

Mr. MOODY. So we may have to use rules of thumb here. But it looks to me like the profitability of invested dollars, be they equity or borrowed dollars, would be enormous. If it is 15 or 13 percent of

revenue, I do not know many businesses that would not like to have 13 percent profitability on their flow of revenue.

Mr. GANDHI. Well, without actually making the calculations ourselves, it is difficult for us to tell you what the rate of return on equity is.

Mr. MOODY. Maybe somebody—maybe I am talking to the wrong people—can try to compute the value of investment relative to the flow of premium. There may be some rules of thumb in the industry. I do not know.

Mr. GANDHI. Yes. Now, we do have some numbers, we do have some numbers in terms of the——

Mr. MOODY. I am sorry?

Mr. GANDHI. We do have some numbers in terms of rate of return on equity for the insurance industry as a whole.

Mr. MOODY. Right. That we know. But do we have any independent readings to know whether or not rate of return on malpractice is higher than on other forms of insurance?

Mr. GANDHI. No.

Mr. MOODY. We don't. We just cannot say?

Mr. GANDHI. No. It is difficult for us to say.

Mr. MOODY. Right.

Mr. GANDHI. And then again, as Mr. Thompson pointed out, there are measurement problems because this is one of the longest of the lines in the insurance industry.

Mr. MOODY. Right.

Mr. GANDHI. It takes quite awhile——

Mr. MOODY. For example, let's take life insurance. Someone probably knows what the rate of net revenue is on every $100 of gross revenue in life insurance because they also have a very long tail and have some of the same similarities.

Mr. GANDHI. However, in case of life insurance though, the certainty is much greater than what you will find in property casualty lines.

Mr. MOODY. Right. A much smaller variance.

Mr. GANDHI. That is right. And actually you could be quite certain about the profitability of our insurance industry. It is very difficult in case of medical malpractice.

Mr. MOODY. In medical malpractice, we have a fat tail distribution here of large variance relative to the mean.

Is that because the company segments the market by line and business and by insurance—by groups they cover rather than because a big pool of large numbers is not in play if you insure a very small segment of the market at any given time?

Is that why the variance is so wide, or is that we inherently just cannot predict malpractice outcomes because they are so random?

Mr. GANDHI. It is just all mixed up on both, sir. Because medical malpractice is about 2 percent of the entire industry. It is a small line.

But, at the same time, the problems of predictability of profitability of this particular line are extremely difficult because it is a long line, because of the complexity, regional complexities Mr. Bowsher identified——

Mr. MOODY. And because different States have different laws, and because even within States some courts may behave very dif-

ferently, and all those reasons, the law of large numbers does not click in the way it would in, let's say life insurance, where you die or you do not die. That is it. You do not have to go to court to find out if you die.

Mr. GANDHI. Yes, sir.

Mr. MOODY. They will probably come up with that one later. [Laughter.]

Mr. GANDHI. Yes.

Mr. MOODY. By the way, some States have different definitions of death, and maybe we will get to it. [Laughter.]

Mr. GANDHI. Well.

Mr. MOODY. Brain dead, body dead, brain waves, pulse.

Mr. BOWSHER. If I could also——

Mr. COYNE. Yes, Mr. Bowsher.

Mr. BOWSHER. If I could also say there has been a change in this industry that some of the coverage has moved out of the traditional insurance companies into what some people refer to as captive insurance companies. Larry has more information on them.

But I think any time you are looking at the insurance coverage in this malpractice area, you have to recognize that the professions has set up some unique and special insurance companies in recent years here because of the availability issue as much as the affordability issue.

Mr. MOODY. Right. And some States by the way have set up risk pools that are State managed as well.

Mr. BOWSHER. Yes, that is right.

Mr. MOODY. Not just doctor managed but State managed.

Mr. BOWSHER. Yes.

Mr. MOODY. So that further makes it harder to generalize about the industry because it is broken up into so many small categories and, therefore, the statistical conclusions are much tougher to reach.

In Wisconsin we did have a phenomena of soaring costs, and then suddenly they came down. There seems to be a lot of unknowns and over-compensation of expected risks.

Mr. BOWSHER. And as we pointed out before, Mr. Chairman, and it is in the back of our full statement here, there are tremendous differences between insurance premiums by locality in this country and, of course, by specialty.

And so any kind of a study here really has to be looking at areas, you might say.

Mr. MOODY. There is no national market, that is clear, as opposed to life insurance, where it does not matter what State you are in.

Mr. Bowsher, that suggests a possible conclusion. With the market that segmented, and with that many proprietary packages being provided and being fairly segmented from another leads to the suggestion that the market is fairly monopolized, not in the sense of peer monopoly, but monopolistic competition with a sloping demand curve. Maybe oligopoly behavior is an appropriate model to think about. This suggests that there may not be a tight fit between medical malpractice reform and the actual reduction in premiums to the physicians and hence to public insurance—Medicare—or other insurance picking up the final bill.

There may be enough play in the system because of these monopolistic institutional arrangements so the profits may be fairly substantial. That means you might cut the profit a little bit, but not necessarily cut the cost if you engage in some reforms.

Do you see what I am saying? It is hardly a perfect competition environment.

Mr. BOWSHER. I will let my economist answer that question.

Mr. MOODY. Do you see what I am trying to get at? I am not saying it very well. [Laughter.]

But do you do you see what I am trying to say? It is not a purely competitive market by any means. In fact, it is the opposite of the purpose. Therefore, the fit between cost and the cost of the insurance and the impact to the patient may be very loose.

Mr. THOMPSON. I agree with where you came out on this point. I think one of the reasons the market is unique is it is not easy to change insurers if you are on the claims made type of policy.

Mr. MOODY. Right.

Mr. THOMPSON. Secondly, there is a lot of competition, I think. But it depends upon what year you are in. It is such a cyclical industry that when they get into one of their cycles, which they appear to be in right now, where they are cutting premiums, they are out looking for business.

Mr. MOODY. So there is price competition going on right now?

Mr. THOMPSON. Yes, that is my impression.

Mr. MOODY. Price competition as opposed to service competition.

Mr. THOMPSON. Three years from now, they may be all running in the other direction so that you do have these cycles where it is very competitive and where it is very uncompetitive.

Mr. MOODY. But that itself is a hallmark of oligopolistic behavior.

Mr. THOMPSON. That is it. And it is going to make the translation between reforms and premiums rather murky as you suggest.

Mrs. JOHNSON. Would the gentleman yield?

Mr. MOODY. Certainly.

Mrs. JOHNSON. Do you have any information about self-insured institutions? More and more hospitals have gone to self-insurance.

Does your experience shed any light on this issue that my colleague has raised?

Mr. THOMPSON. We know that there has been a movement towards self-insurance. It has become more important in hospitals, either individually, or they tend to band together in groups of like hospitals, and risk retention groups or something like that.

I do not think we have any data on their cost experience.

Mrs. JOHNSON. But, anecdotally, hospitals that I am acquainted with that have done this, speak to their much greater ability to monitor care and control costs. And it would be worth looking at if we had the ability.

Mr. THOMPSON. I think some of the specialty insurance institutions that have grown up in the last 15 years or so, have been much more active in risk management programs and trying to encourage their participants to be more attentive to managing that process.

Mrs. JOHNSON. Thank you.

Mr. MOODY. I will just conclude with one final point. I appreciate your bearing with me as I have tried to formulate my questions here.

If there is this slight cyclical swing of price competition and premium cutting, followed by another period of what looks like exit from the market and, therefore, prices go up, is it conceivable that price cutting would go too far? Could you have companies with net negative worth, actuarially speaking, that might have to walk away and declare bankruptcy? Would the public sector be left picking up the costs?

Mr. BOWSHER. Yes.

Mr. MOODY. It is something to think about.

Mr. BOWSHER. Yes, I think there is no question that in the last decade a fair number of companies did walk away from it because of what they perceived as the risk. And I also think because of what Natwar was pointing out, the long-term risk, in other words, not knowing quite what the liability was going to be.

Mr. GANDHI. As Mr. Bowsher pointed out, I think the fundamental problem in case of insurance is that they deal in the future. They really do not know the cost of goods—so this is kind of an accounting version.

The answer here is that you have to know what the cost is. In case of medical malpractice, for example, because of its long tail it is a problem. But, as opposed to this, if you went to take automobile insurance, for example, where the tail is very short, they could be far more precise in terms of what their profitability is, and also in terms of projecting the premium increases.

Mr. MOODY. Because with a long tail, you really have an open-ended exposure. You do not really know what it is so you are being risk adverse. You have to put your premiums high enough to cover all eventualities.

This bears a lot of the same hallmarks. This insurance industry seems to bear a lot of the same hallmarks as insurance for toxic waste.

Mr. BOWSHER. I think that is a very good example.

Mr. MOODY. Thank you very much.

Mr. COYNE. Thank you, Mr. Bowsher and the panel. Appreciate your testimony.

Mr. BOWSHER. Thank you very much, Mr. Chairman.

Mr. COYNE. Our next panel includes four witnesses representing each of the four groups involved in the medical malpractice system—physicians, lawyers, patients and insurers. The committee is pleased to welcome Dr. James Todd, acting executive vice president of the American Medical Association; Mr. Russ Herman, president of the Association of Trial Lawyers of America; Mr. Perry Amsden, representing the American Association of Retired Persons; and Mr. Donald Fager, chairman of the Legislative Oversight Committee of the Physician Insurers Association of America.

Dr. Todd, maybe you can begin with your testimony.

STATEMENT OF JAMES S. TODD, M.D., ACTING EXECUTIVE VICE PRESIDENT, AMERICAN MEDICAL ASSOCIATION

Dr. TODD. Thank you, Mr. Chairman.

I am Jim Todd, a surgeon and the acting executive vice president of the American Medical Association. For 10 years, I was chairman of the board of the New Jersey State Medical Underwriters, a physician-owned liability insurance company, and have been a past president of the Physician Insurers Association of America.

In my formal statement, I have detailed the circumstances and facts that characterize the continuing medical liability crisis, and the effects of that crisis on health care delivery in America. Although the tangible consequences of the crisis are serious in terms of cost and access to care, the intangible effects are also of great concern. It is the loss of trust and confidence between the physician and the patient that may in the long run be the most significant result of today's liability system. Instead of looking to each other as partners in a collaborative effort, patients don't trust their physicians, and physicians have begun viewing their patients as adversaries against whom defensive medicine must be employed. It is within this atmosphere of fear and mistrust that we must address reforming the current system to assure equity, both for patients and physicians.

At the outset, let me stress that medical care in this country is extremely safe. Based on the Harvard study in New York, it can be estimated that at least 99 percent of medical care is provided safely. This is a dramatic finding that speaks to the competence of the medical profession as a whole.

Yet in an imperfect world, mistakes occur despite our continual efforts to improve patient safety. When patients are harmed by negligence, they should be fairly and promptly compensated, and they should have access to the most effective dispute resolution mechanisms. To that end, medicine has worked hard for enhanced patient safety and an improved system of compensation for deserving patients.

We have vigorously advocated reform of the tort system, and if a better system can be demonstrated, we would even support replacement of the current system. In States where tort reforms have been allowed to stand, such as California, premiums have leveled, and the crisis mentality has abated. We believe a national minimum level of tort reform should be adopted, including a cap on damage for noneconomic loss at $250,000 or less, offset of collateral source benefits, periodic payment of future damages, suspension of the statute of limitation for minors to no more than 6 years from birth and decreasing sliding scale regulation of attorney contingent fees.

Beyond tort reform, we believe that a fault-based administrative system such as the one developed by the AMA Specialty Society Medical Liability Project may provide an effective forum and process for dispute resolution in certain circumstances, and certainly should be demonstrated. The Medicare arbitration bill introduced last week by Representative Nancy Johnson is another example of the type of legislation that would benefit patients and society. The bill would provide for binding arbitration of medical liability claims and promises relief from the current system by reducing time and transaction costs. We are committed to working closely with Representative Johnson on her innovative bill.

Recognizing our responsibility to minimize avoidable patient injury, the medical profession has undertaken numerous patient safety efforts referred to as "risk management" or "risk prevention." Risk management entails examining the facts of medical accidents to identify high-risk situations, and then educating physicians to avoid these situations. This seemingly simple concept has dramatically enhanced patient safety and, because of its focused nature, is the best way to educate physicians about the risk factors in their particular practices. This risk management concept forms the basis for the many risk management tools that, as detailed in my written testimony, have been incorporated into medical practice, hospital procedures, and underwriting criteria across the country.

Our activities include establishment in 1986 with more than 30 national medical specialty societies of a project to jointly address liability issues. This group has undertaken development of several practical risk management tools, such as the "Compendium of Patient Safety and Medical Risk Management Programs." The liability project's many other risk management efforts evidenced by the many materials that were provided to the subcommittee members, are detailed in my written testimony.

In June, we will publish a risk management resource book developed for residents and young physicians, produced in conjunction with the Harvard Risk Management Foundation.

We established in 1987 an office of quality assurance to promote the development of practice parameters that address effective clinical practice and appropriate utilization.

We have initiated a program to review our membership on a continuing basis, and withdraw membership from those physicians found to be incompetent or unethical. In January, formal expulsion proceedings were initiated against 31 AMA members, and a commitment was made to assist any State or county medical society to take similar action.

In closing, it is extremely difficult in 5 minutes to describe adequately the concerns, frustrations, activities and achievements of the past 15 years. You cannot overestimate the impact that the liability battles have had on physicians across the country. The AMA did not easily arrive at the conclusion that Federal intervention was appropriate in this area. However, we feel that the current system, without change, will continue to have negative impacts on the quality and cost of patient care. Consequently, the inability of States to achieve or maintain widespread reform has led us to the Congress. The system is in urgent need of repair. It can and should be fixed as quickly and equitably as possible.

Thank you, Mr. Chairman. At the appropriate time, I will be happy to answer questions.

[The statement and attachments of Dr. Todd follow:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Health Subcommittee

of the

Committee on Ways and Means

United States House of Representatives

Presented by
James S. Todd, MD

RE: Medical Professional Liability

April 26, 1990

Mr. Chairman and Members of the Committee:

My name is James S. Todd, MD. I am a surgeon and the Acting Executive Vice President of the American Medical Association. With me today are Nancy Bannon and Denise Andresen of the AMA's Division of Legislative Activities. The AMA is pleased to have this opportunity to testify regarding the very serious status of medical professional liability in this country.

Mr. Chairman, in announcing this hearing, you stated that "The current malpractice system serves no one." We couldn't agree with you more. The current tort system as it exists in many jurisdictions does not accomplish either of the goals of dispute resolution -- compensation for those injured due to negligence and deterrence of such negligence -- and is fraught with inequities. In fact, medical liability litigation, accurately dubbed "high stakes" litigation by the RAND Corporation, has created numerous problems for this country's health care system, to the detriment of patients, physicians, society and the federal government -- the largest single purchaser of health care in this country.

Defining the Problem

For many years, this country has grappled with the growing inability of the tort system to resolve medical liability claims in a timely and cost-effective manner. The debate has intensified during the past two decades as medical liability crises have escalated and receded, and as society has shouldered the "side effects" of the crises.

As we begin the decade of the '90s, the issue of professional medical liability remains heated. However, studies performed in the late 1980s by a Department of Justice-based Tort Policy Working Group, the General Accounting Office and a Department of Health and Human Services Task Force on Medical Malpractice and Insurance confirm that a consensus has been reached: the current tort system, without substantial modification or reform, is unable to resolve medical liability claims effectively and efficiently.*

*These studies also reached agreement that the California reform model most effectively discourages frivolous claims, promotes settlement of valid claims and expedites claims resolution.

This consensus has been reconfirmed by new evidence from the "Report by the Harvard Medical Practice Study to the State of New York," that suggests the current system provides access to only a fraction of the persons with potentially valid claims, yet ineffectively screens out non-meritorious claims. When claims are filed, they can remain unresolved for 5 to 10 years. "Transaction costs" of 50% or more are the norm, with the result that less than half of every dollar spent in litigation goes to compensate injured patients.

In defining the medical liability problem, it is important to note that medical care is safe for the vast majority of all patients. In fact, the recent Harvard Study showed that only 1% of the patients were subjected to negligent care of any kind while hospitalized in New York State in 1984, and three-quarters of the injuries were classified as minimal or moderate in degree. Thus, inferring from the Harvard Study, medical care is safe for 99% of all patients. This is a dramatic finding that speaks to the professional competence of the profession as a whole.

It is also important to note what the problem is not -- medical negligence is not the fault of "bad" or "incompetent" doctors. Rather, studies have shown that all doctors, even the best doctors, can and do make mistakes. We submit that avoidable mistakes are never acceptable. The medical community -- and, increasingly, the medical liability insurance community -- is committed to continuing its efforts to reduce the incidence of injury even further. Their efforts alone, however, are not enough to remedy the many harms that the tort system in its current form perpetuates.

Patients Are Harmed

The AMA strongly believes that patients who have been injured due to negligence should be fairly compensated, and that our dispute resolution mechanisms should promote that goal. Unfortunately, the current system has failed the patient population. The Harvard data show that of the 1% of patients whose medical records indicated some negligent treatment, only 12.5% filed liability claims. Significantly, only half of those patients -- 6.25% -- received compensation from the tort liability system.

Other data show that even when patients pursue compensation, they are not the primary beneficiaries of the system. Rather, attorneys' fees and expenses (both plaintiff and defendant) account for 38% of total monies spent on resolving medical liability claims. (See Appendix A.) Ironically, although our system is ostensibly designed to compensate the injured, the RAND Corporation estimates that only 43 cents of every dollar spent in medical liability litigation reaches an injured patient.

In addition, patients typically wait much too long for resolution of their claims -- six to ten years in most urban areas. The time and cost commitment involved in pursuing medical liability litigation denies injured patients meaningful access to the legal system by discouraging attorneys from accepting cases where damages are not expected to be very high.

Physicians Are Harmed

Medical liability awards soared by more than 1000% from 1960 to 1984. A study reported in 1988 showed that the average doctor now has a 37% chance of being sued for professional liability in his or her lifetime. The percentage increases to 49 for a surgeon and 71 for an obstetrician. The potential of being sued is not limited to physicians who practice high-risk specialties; since the early 1980s, the number of claims filed against family practitioners has more than doubled. Since 1985, the specialties with the highest annual increases in liability premiums have been pediatrics and psychiatry.

Perhaps the most compelling evidence of the current system's failure is the fact that a physician's chance of being sued for medical liability bears almost no relation to whether he or she has been negligent. The recently published Harvard data show that 80% of the claims for medical negligence filed in court in New York did not correspond with a negligent adverse event. Stated differently, of the total plaintiffs who sued

their doctors, only 20% had cases with evidence of a negligent adverse event. These findings reinforce the General Accounting Office's estimate that nearly 60% of all claims filed against physicians are dismissed without a verdict, settlement or any payment of compensation in the plaintiff's favor (1987 GAO Report "Medical Malpractice, Characteristics of Claims Closed in 1984").

The message implicit in these facts and figures is that the current tort system as it functions in most states is not effectively resolving medical liability claims or deterring medical negligence. Physicians are for the most part not being sued because they are negligent. They are being sued primarily because they practice an imperfect science, one that is subject to myriad variables, and that, therefore, can produce unpredictable -- sometime unfortunate -- results. President Bush acknowledged this fact in a recent speech at Johns Hopkins University, during which he called for restoring "common sense and fairness" to the current medical liability system. The President stated: "We've got to remember a simple truth: not every unfortunate medical outcome is the result of poor medicine, and you cannot make life risk-free." We believe that this "simple truth" has been lost in the chaos of the present system.

Society Is Harmed

Although patients and physicians are most directly harmed by the present liability system, society as a whole also is harmed. The spiraling costs generated by the present system are borne by everyone. One component of the cost issue is the exorbitant amount attributable to physicians' (and other providers') professional liability premiums, which have been a primary factor contributing to recent years' growth in patients' medical bills. In the 1980s, professional liability premiums were by far the fastest growing component of physicians' practice costs, increasing at an annual average rate of 18.3% between 1982 and 1988. (See Appendix B.) Average premiums paid by self-employed physicians more than tripled in the 1980s, and annual increases of more than 20% were commonplace. The cost is especially heavy for some high-risk specialists whose premiums have reached $200,000 annually.

Incredibly, by the most conservative estimates, more than 50 cents of every premium dollar paid by physicians is spent on the overhead costs of preparing for and conducting a jury trial. Moreover, up to 43% of insurer costs are spent defending non-meritorious claims that are ultimately closed with no indemnity payments to claimants. These facts are a testament to the gross inefficiency of the current system.

Yet another aspect of the liability cost factor is the cost attributable to the practice referred to as "defensive medicine." Aptly named, defensive medicine is a phenomenon whereby physicians, faced with a 37% chance of being sued regardless of the quality of care they provide, defend against future liability claims by providing treatment or testing in cases where those services might not be provided absent the fear of litigation. A study by Medical Economics found that as a result of this practice, 70% of physicians order more consultations, 66% order more diagnostic tests, 54% order more follow-up visits and 28% perform procedures they ordinarily would have delegated to other medical personnel. We estimate that this practice added up to $19.3 billion to the cost of health care in 1988.*

Another societal harm from the present system, noted by the President in his speech at Johns Hopkins, is that the threat of liability likely inhibits medical innovation. Although there are no definitive data on this point, oncologists have reported reluctance to prescribe experimental therapies because of fear of untoward side effects. As President Bush noted, "'No risk' means 'no progress', and that's not the American way." Yet "no progress" is precisely what this country risks if the present system is allowed to continue unfettered.

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*Like other defensive measures, all defensive medicine is not necessarily overuse, but can reflect necessary improvements in patient care.

Finally, perhaps the most serious societal harm caused by the liability system is reduced access to health care. Increasing premiums and the threat of liability have caused physicians to abandon certain procedures and areas of the country. A 1984 survey by the American College of Surgeons indicated that 38% of surgeons referred or refused to accept high-risk cases because of liability concerns. In addition, 50% of all physicians in Illinois, a state known for its steep insurance rates and generous juries, have reported that they no longer perform certain medical procedures. Former HHS Secretary Bowen's task force on liability reported, in 1987, decreased access attributable to liability in 26 states, with obstetrical and gynecological services the most likely to be affected, and low-income individuals the most likely to be deprived.

The following figures, obtained by the American College of Obstetricians and Gynecologists in response to a 1987 survey, confirm the access problem: 12.4% of the respondents stated they no longer practiced obstetrics, 12.9% decreased the number of deliveries and 27.1% decreased the volume of high-risk obstetrical care they provided. Even larger numbers of family practitioners have discontinued deliveries, and some states have large areas with no providers of obstetric care -- 57 counties in Georgia, 28 in Alabama and 19 in Colorado, to name a few.

Even where obstetrical services are available, they are often so costly that many individuals are denied access. In Florida, for example, liability insurance adds $1225 to the cost of delivering a baby. In New York and Arizona, the additional cost is $644 and $503, respectively. Given the greatly reduced access to obstetric care, it is not surprising that infant mortality, an area in which this country has always been deficient, is now rising in some places.

Access by all Americans to health care has become a serious national priority that is receiving unprecedented interest and support. Almost daily, headlines reflect the progress of the many commissions and advisory groups, such as the U.S. Bipartisan Commission on Comprehensive Health Care, the Social Security Advisory Commission and the Internal Health and Human Services Task Force, that are studying the access problem and proposing solutions. Access is also a priority for the AMA, which recently released its Health Access America proposal for ensuring access by all to health care.*

We urge this Committee to recognize that the current professional liability system significantly and directly impairs access. Containing the escalating cost of medical liability offers an effective element to the solution to the access problem that would not entail federal expenditures.

This litany of problems with the current tort system does not necessarily mean that the system must be abandoned. In fact, the profession and legislatures in a handful of states have successfully initiated reforms that address many of the concerns that we have verbalized.

We believe that a fault-based system that lowers the barriers to legitimate claims and reduces transaction costs can meet the needs of society. Reforms such as those adopted in the states of California and Indiana tell us that the current system is a good candidate for reform, and that reform can have dramatic effects of promoting settlement of valid claims, discouraging frivolous litigation and reducing the time required for claims resolution.

The Medical Community's Response

Mr. Chairman, in announcing this hearing, you stated that all parties to the health care system--patients, lawyers, physicians and insurers--must be willing to make compromises to craft an effective solution to the professional liability problem. We agree that the responsibility is a shared one, and acknowledge that it is the provider community's particular responsibility to do whatever it can to minimize the incidence of avoidable patient injury.

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*Attached as Appendix C is a listing of the 16 main points of the AMA's proposal.

Providing medical care today involves a complex system of persons and equipment, each component of which is necessary to bring about the safe and effective delivery of care to the patient. While science and technology have greatly advanced the frontiers of medicine, providers are being confronted with multiple systems problems inherent in today's medical care--training problems, communication problems, equipment problems, documentation problems, and so on.

Over the past decade, the profession has vigorously addressed these systems issues under several different rubrics, including "patient safety," "loss prevention" and "risk prevention." All aim at the common goal of preventing patient injury. All call upon us to examine what we do or fail to do, and how we do it. When problems are detected, solutions are developed and implemented. Some of these solutions are remarkably simple, little more than the systematic application of practical wisdom. Others are far more sophisticated, derived from complex sampling and statistical analysis techniques.

To take one example, in the early 1980s a group of anesthesiologists in Washington state, concerned with the incidence of loss in their high risk specialty, did a study of the circumstances underlying alleged negligent medical events. Analyzing liability insurers' closed insurance claim files, the group determined that for the most part, these losses could not be anticipated from the claims history of individual physicians. Rather, claims occurred almost randomly. The study's results confirmed that liability was not simply the problem of a few "bad apples" in the profession Even the finest doctors were incurring losses.

Certain scenarios were identified, however, during which an error was more likely to occur. With these findings, the anesthesiologists initiated a process within their national medical specialty society to develop informational materials and guidelines that enabled providers to identify high risk situations and avoid injury. As a direct result of this effort, errors in the anesthesia field were dramatically reduced and the specialty's insurance classification and premiums dropped substantially.

The phenomenal success of this risk management approach led to its eventual adoption as a condition of insurance by every liability insurer that covers anesthesiologists, a very effective private regulatory mechanism. Moreover, it fueled the interest in all quarters of the medical community to develop what has now become a broad and prolific assortment of patient safety initiatives, encompassing closed-claims studies, guidelines and policy statements, seminars, self-assessment surveys and self-study programs, among many others.

These efforts have been furthered and often led by the physician-owned insurance companies, which embraced early on the "gospel" of risk management and invested substantial resources in promoting it. All but two of the forty-three member companies of the Physician Insurers Association of America (PIAA) are not-for-profit entities, owned by their insureds. In contrast to commercial insurers, any net income they post is translated directly into lower premiums, thus providing a further incentive for their insureds to avoid loss. The PIAA companies also play an active role in policing the profession through aggressive underwriting practices which deny coverage to physicians who fail to practice safely.

In addition to these profession-based actions, in 1987 the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) began implementing a revolutionary quality improvement mandate in the nation's hospitals. Called the "Agenda for Change," its objectives are to create standards that provide a foundation for continual quality improvement activities within health care facilities, establish performance monitoring indicators and improve assessment of facility compliance with JCAHO standards. The Agenda also calls for the development of "clinical indicators of quality" to enable better analysis of the quality of patient care. In addition, the Agenda calls for an ongoing data collection and monitoring system to provide continuous feedback to institutions regarding the quality of care.

These efforts clearly represent a new era in the medical community's ability to respond aggressively to patient safety concerns. It should be noted that the frequency of medical liability claims filings has leveled off and, in some states, even decreased since approximately 1986. While it is still too early to evaluate the meaning of this trend conclusively, the tremendous growth of patient safety activities in the 1980s may indeed be a contributing factor. If the Harvard Medical Practice Study was repeated with data from 1990 instead of 1984, it is likely that the incidence of patient injury would be even further reduced.

The AMA's Response

We strongly believe that the patient safety movement currently being implemented by the medical community is the optimal source of information and education for providers on injury prevention issues. These activities are data-based, innovative and amenable to modification as new problems arise. Mistakes occur when physicians apply their academic and clinical training to particular patients. To best prevent errors, we must study the facts of loss situations, identify high-risk circumstances and educate physicians in a focused manner on how to avoid them.

The AMA is actively working to further the goal of patient safety. In 1986, the AMA together with more than thirty national medical specialty organizations established the AMA/Specialty Society Medical Liability Project (AMA/SSMLP) to jointly address liability issues. Among its purposes, the AMA/SSMLP is dedicated to furthering innovation in the loss prevention field and has a standing Patient Safety/Risk Management Subcommittee. Through this subcommittee, the AMA/SSMLP monitors patient safety initiatives and disseminates information to hospitals, medical societies, insurers and others to promote the exchange of ideas and approaches.

The AMA/SSMLP also has undertaken development of several practical risk management tools. In 1988, it published together with the PIAA the Compendium of Patient Safety and Medical Risk Management Programs, a 160 page catalog of the risk management activities of state and national medical societies, insurers and others, complete with subject matter index and the identities of key contact people to facilitate networking among professionals across the country. Slated to be updated later this year, it remains the most comprehensive source of medical loss prevention information available. (Copies have been made available to the Subcommittee.)

The AMA/SSMLP has followed this initial contribution with a new document entitled Principles and Commentaries on Risk Management for the Medical Office. Developed in consultation with nationally known experts over a two year period, the publication sets forth in twelve chapters pragmatic risk management advice primarily for office-based practices. The chapters cover such topics as obtaining informed consent, establishing good communication with patients, developing workable follow-up systems for responding to patient telephone calls and missed appointments, instituting schedules for the maintenance and calibration of equipment and evaluating the safety of office and parking area grounds, among others. As is true with all good risk management tools, the material collected in this work is data-based, drawn from the experience of insurers, defense lawyers and professional risk managers. (The Principles and Commentaries, which is scheduled for publication in May, 1990, has been provided to the Subcommittee members.)

Also on the agenda of the AMA/SSMLP is finalizing an integrated risk management program now being pilot tested by the Oregon Medical Society Association. The program's two-fold purpose is to offer risk prevention advice and collect data to be used as a continuous feedback mechanism on the effectiveness of loss prevention efforts. The program consists of an office self-assessment survey, a self-study course and an office site visit and assessment by a professional risk manager -- which together constitute a single learning process that is adaptable to any specialty. The pilot phase is expected to be completed in late 1990, and the program is designed to be easily implemented by state, county and local specialty societies across the nation.

In addition to these activities, in June, 1990 the AMA will publish a risk management resource book developed for residents and young physicians that we produced in conjunction with the Harvard Risk Management Foundation. Entitled Grand Rounds on Medical Malpractice, the text was originally written by a young Harvard Medical School graduate. The text will be used by the Harvard Medical School next year, and will also be available as a CME risk management course for practicing physicians.

These targeted injury prevention efforts represent only a few of the many activities undertaken by AMA and others to continually improve the quality of medical care. In 1986, the AMA began a major initiative to expand its traditional leadership and reaffirm the profession's commitment to self-regulation. As part of this initiative, the AMA established in 1987 a new Office of Quality Assurance to promote the development of practice parameters that address effective clinical practice and appropriate utilization. The AMA's quality assurance activities are outlined in the Association's Health Access America proposal.

Most recently, the AMA has initiated a program to review its membership on a continuing basis and withdraw the privilege of membership from those physicians who have been found to be incompetent or unethical. (See Appendix D.) In January, 1990, formal expulsion proceedings were initiated against 31 AMA members, and a commitment was made to assist any state or county medical society to take similar action. (See Appendix E.) This commitment includes providing guidance on the appropriate procedural steps and safeguards that must followed, and paying the litigation expenses incurred by medical societies or their members in discharging this responsibility -- a factor that has chilled action of this nature in the past.

We recognize that this latest action does not eliminate the danger posed by the small population of aberrant practitioners that threaten the safety of their patients. We offer it as one more affirmative step in a continually expanding effort to minimize this danger wherever possible.

The Federal Response

Mr. Chairman, we believe that the medical community is actively carrying out its responsibility to work toward a solution for the medical professional liability disaster. We hope that the other participants in the system will heed your call to work for a solution. We believe, however, that a contributor to any viable solution must be the federal government.

As I stated previously, this country's tort system has been ineffective at resolving medical liability claims. Patients are not the primary beneficiaries of awards. Physicians are sued, often regardless of any fault, and suffer from the protracted process. Transaction costs continue to spiral, fed by the inefficient system, and most states have been unable to effect reforms that can withstand state law constitutional challenges.

The AMA and state medical societies have striven for effective tort reform for over fifteen years. While some states, such as Indiana and California, have achieved success, most states have been unable to achieve reform. Fifteen years of legislative battles, court defeats and exponential premium growth have forced us to conclude that the only viable solution is a national one. We believe that federal intervention is crucial at this juncture.

At a minimum, the liability rules should be revised to cap damages for non-economic loss at $250,000 or less, require offset of collateral source benefits, provide for periodic payment of future damages, limit suspension of the statute of limitations for minors to no more than six years from birth and require decreasing sliding scale regulation of attorney contingent fees. We also support requiring a certificate of merit as a condition to filing a medical liability suit, and imposing minimum expert witness criteria. Finally, we believe that a fault-based administrative system, such as the one designed by the AMA/SSMLP, may provide a forum and process for dispute resolution far superior to the present system.

The Medicare arbitration bill introduced one week ago by Representative Nancy L. Johnson is a prime example of the type of federal relief that patients, physicians and society as a whole require. The bill, which would provide for fault-based binding arbitration of medical liability claims between Medicare beneficiaries and their caregivers, promises relief from the current system by implementing essential reforms. We are committed to working closely with Representative Johnson on her innovative bill, and we hope that the Congress will follow her lead by extending tort reform beyond the Medicare arena.

Conclusion

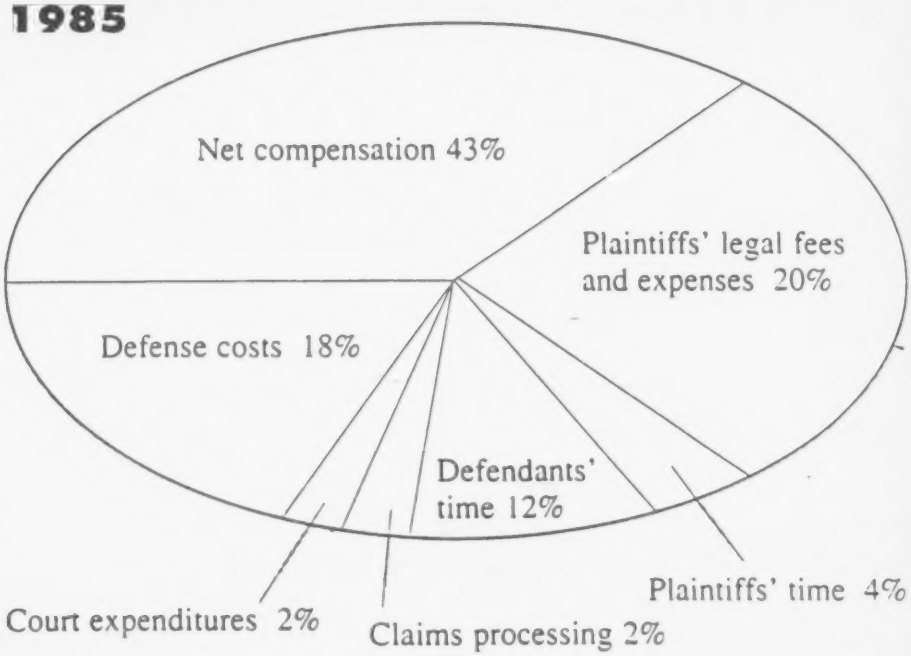
Mr. Chairman, the liability crisis is not new to the medical profession. The current crisis is, in reality, an extension of crises dating back to the mid 1970s, when the first crisis was caused by the withdrawal of major insurance underwriters from the market. The second major crisis, in the early to mid '80s, was a cost crisis precipitated by tremendous growth in premiums. The current crisis, which involves both cost and access, validates what physicians have been saying for 15 years -- the system is broken. It needs to be fixed.

It needs to be fixed to meet the needs of the real parties at interest -- the injured patients who need to be fairly compensated, the physicians who are willing to assume their fair share of the burden from negligent practice, and society, which needs to reduce transaction costs, eliminate windfall judgments and assure that physicians can still offer medically necessary services in an atmosphere of fairness to all parties.

The AMA appreciates the opportunity to appear before this Committee. At this time, we will be pleased to respond to questioning.

APPENDIX A

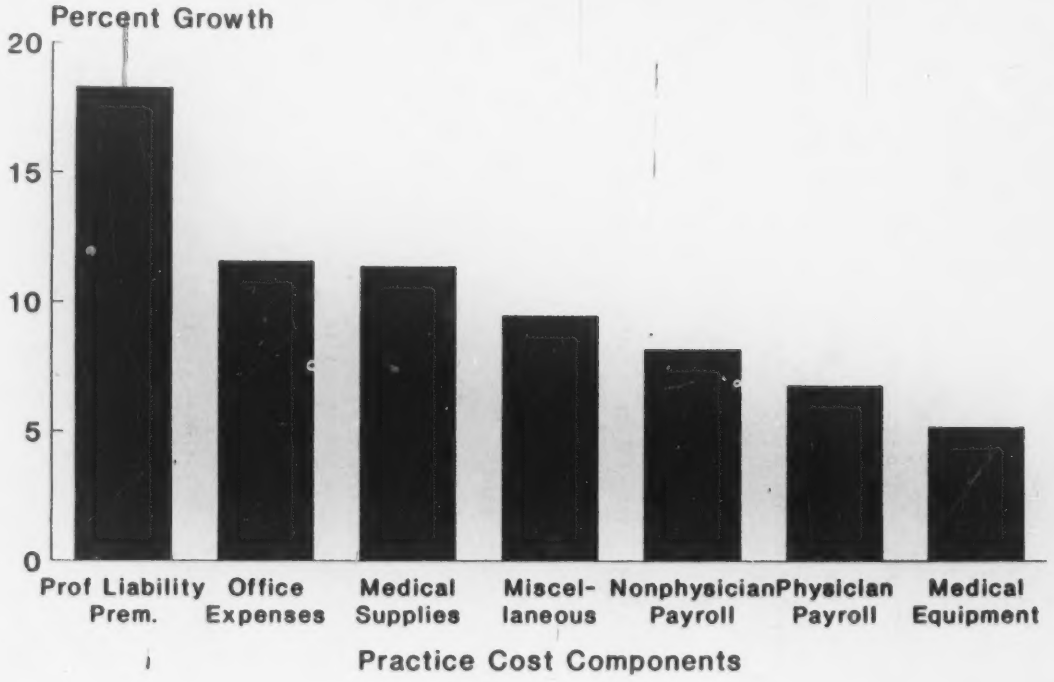
Plaintiffs' Net Compensation and Various Costs as a Percentage of Total Expenditures in Average Non-Automotive Torts (Including Medical Liability Claims), 1985



Note: Percentages are based on the average of two estimates, and may not sum to 100 due to rounding.

Source: The RAND Corporation Institute for Civil Justice.

Annual Growth Rates in Medical Practice Cost Components, 1982-1988



APPENDIX C

HEALTH ACCESS AMERICA

The sixteen-point proposal

The AMA proposal is a blueprint for extending access, controlling inappropriate health care cost increases, and sustaining the Medicare program to assure proper health care for all. It is summarized as follows:

1. Effect major Medicaid reform to provide uniform adequate benefits to all persons below the poverty level.

2. Require employer provision of health insurance for all full-time employees and their families, creating tax incentives and state risk pools to enable new and small businesses to afford such coverage.

3. Create risk pools in all states to make coverage available for the medically uninsurable and others for whom individual health insurance policies are too expensive and group coverage is unavailable.

4. Enact Medicare reform to avoid future bankruptcy of the program by creating an actuarially sound, prefunded program to assure the aging population of continued access to quality health care. The program would include catastrophic benefits and be funded through individual and employer tax contributions during working years. There would be no program tax on senior citizens.

5. Expand long-term care financing through expansion of private sector coverage encouraged by tax incentives, with protection for personal assets, and Medicaid coverage for those below the poverty level.

6. Enact professional liability reform essential to reducing inordinate costs attributable to liability insurance and defensive medicine, thus reducing health care costs.

7. Develop professional practice parameters under the direction of physician organizations to help assure only appropriate, high quality medical services are provided, lowering costs and maintaining quality of care.

8. Alter the tax treatment of employee health care benefits to reward people for making economical health care insurance choices.

9. Develop proposals which encourage cost-conscious decisions by patients.

10. Seek innovation in insurance underwriting, including new approaches to creating larger rather than smaller risk spreading groups and reinsurance.

11. Urge expanded federal support for medical education, research and the National Institutes of Health, to continue progress toward medical breakthroughs which historically have resulted in many lifesaving and cost-effective discoveries.

12. Encourage health promotion by both physicians and patients to promote healthier lifestyles and disease prevention.

13. Amend ERISA or the federal tax code so that the same standards and requirements apply to self-insured (ERISA) plans as to state-regulated health insurance policies, providing fair competition.

14. Repeal or override state-mandated benefit laws to help reduce the cost of health insurance, while assuring through legislation that adequate benefits are provided in all insurance, including self-insurance programs.

15. Seek reductions in administrative costs of health care delivery and diminish the excessive and complicated paperwork faced by patients and physicians alike.

16. Encourage physicians to practice in accordance with the highest ethical standards and to provide voluntary care for persons who are without insurance and who cannot afford health services.

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APPENDIX D

II. AMA INITIATIVE ON QUALITY OF MEDICAL CARE AND PROFESSIONAL SELF-REGULATION – REVIEW OF MEMBERSHIP ROLLS
(Reference Committee G, page 440)

HOUSE ACTION: ADOPTED

Board of Trustees Report QQ (A-86), AMA Initiative on Quality of Medical Care and Professional Self-Regulation, called upon the AMA to review its membership rolls and expel those members who have "engaged in serious misconduct or . . . been found to be incompetent." This report describes the program implemented by the AMA in response to this directive and is provided for the information of the House.

Self-regulation and quality assurance activities lie at the heart of the medical profession's continuing commitment to assure that patients receive high quality medical care. Organized medicine has developed a variety of mechanisms to promote and protect the quality of patient care. Board Report QQ (A-86) catalogues the diverse quality assurance activities pursued by the AMA in such areas as medical education and training, physician credentialing and the support of scientific research, just to name a few. In particular, the goal of effective self-regulation is a priority of the AMA, which has called upon physicians to participate actively in good faith efforts to discover incompetent or unethical practitioners and discipline them or report them to appropriate disciplinary authorities.

Public trust in physicians is founded in part on the belief that organized medicine monitors instances of professional misconduct and acts responsibly to prevent it from occurring. One-third of those polled

in a 1987 public opinion survey taken by the AMA revealed that they trusted associations of physicians most to "ensure that patients receive cost effective and quality medical care." Only independent consumer groups ranked as high and, notably, licensing authorities ranked much lower. Those polled also indicated that they were six times more likely to first communicate any dissatisfaction with their medical treatment to the AMA or a local medical society than to a state licensing board. It appears that many patients construe a physician's membership in a medical society as an endorsement that he is a competent and ethical practitioner.

Physicians' professional associations do have established and effective programs to promote peer review and self-regulation. Nevertheless, they also have been criticized for not taking strong enough action to discipline their own members. The AMA's position as physicians' primary representative in the public's eye requires that it play a leadership role in denying the benefits of membership to physicians found to be unethical or incompetent. Such activity also is called for by the Association's Constitution and Bylaws, which authorizes the AMA Council on Ethical and Judicial Affairs to expel members "for an infraction of the Constitution or these Bylaws, for a violation of the Principles of Medical Ethics, or for unethical or illegal conduct." Accordingly, a physician who has lost his or her license in one jurisdiction for reasons relating to unprofessional conduct or incompetence should be excluded from AMA membership, even though the physician may still be licensed in other states. Similarly, a physician who has engaged in serious unprofessional or immoral conduct should be expelled from the AMA, regardless of whether his or her license has been revoked or restricted by a state board.

A related goal is the assurance that disciplinary actions taken by state licensing boards, the federal government and others involved in quality review is expeditiously communicated to all interested professional organizations. Because physicians may be licensed in more than one state or hold membership in multiple professional societies, a comprehensive system is needed to fully achieve this goal. The AMA, working with the Federation of State Medical Boards (FSMB), already has implemented a vast network of communications to improve the flow of disciplinary information between licensing boards. However, more can be done to ensure that medical professional societies are kept fully apprised of the status of their members who have been the subject of disciplinary action.

The following program directly addresses these concerns:

1. Disciplinary Criteria

The AMA has developed the following criteria for identifying physicians who should be immediately expelled from the Association, subject to the notice and hearing procedures set forth in the Rules of the Council on Ethical and Judicial Affairs:

- Physicians with convictions for fraud or a felony involving professional misconduct or moral turpitude rendered by a court of law or other tribunal with acknowledged jurisdiction;

- Physicians who have had a license revoked or have been forced to surrender a license for reasons relating to incompetence or unprofessional conduct;

- Physicians who have been discharged from the armed forces or government employ for reasons relating to and based on a finding of incompetence or unprofessional conduct.

These criteria for systematic exclusion from the AMA are limited to categories which in almost every case denote incompetence or serious misconduct, and they purposefully do not extend to all disciplinary actions reported against physicians. In fact, physicians are sanctioned for numerous reasons, ranging from late payment of state licensing fees or the infraction of minor administrative rules to serious professional

misconduct. Some of these reported actions have little or nothing to do with competence or ethical conduct. Other intermediate level sanctions, such as probation or a suspension, are imposed over a wide range of criteria, the scope of which varies considerably from jurisdiction to jurisdiction. While these actions usually signify behaviors or impairments of significant concern, they may or may not involve a finding of incompetence or professional misconduct. Moreover, they sometimes involve situations which are being effectively addressed by rehabilitative efforts under the supervision of a medical society or health care institution – efforts which could be unnecessarily impeded by exclusion from membership in organized medicine.

For these reasons, physicians who have had these intermediate types of adverse action reported against them must be individually considered and will not be systematically excluded from AMA membership. Where particular circumstances indicate a serious breach of a member's ethical or professional obligations, the Council on Ethical and Judicial Affairs will investigate and take appropriate action, including expulsion if it is warranted.

Additionally, physicians who meet the exclusionary criteria defined above, but have subsequently demonstrated rehabilitation, should not be absolutely barred from AMA membership for reasons relating to past difficulties which have been fully resolved. Upon request and full disclosure of all pertinent facts, their applications will continue to be considered for approval by the Council on Ethical and Judicial Affairs pursuant to the membership review procedures set forth in the AMA Bylaws and the Rules of the Council on Ethical and Judicial Affairs.

2. AMA Direct Membership

Physicians may hold AMA membership concurrently with membership in a state or county medical society or they may apply directly to the AMA, foregoing involvement at the state or county level. For several years, initial applicants for direct membership have been screened according to an established procedure to determine if they have been sanctioned or otherwise found to have engaged in unethical or illegal conduct prior to the time they applied.

AMA staff has reviewed the Association's membership rolls to identify which of its non-state society members meet the criteria referenced above. Of all physicians reported to the AMA Masterfile as having had any disciplinary action reported against them, no more than 101 were direct AMA members as of year end 1986. Of these, no more than a few met the criteria for automatic expulsion described above. Moreover, most if not all who had been found to have seriously breached their ethical or professional obligations had been sanctioned for the conduct subsequent to becoming a member of the AMA. Thus, existing methods of screening initial applicants for direct membership appear to be successful in preventing unethical and incompetent physicians from joining the AMA.

A two-fold response has now been implemented to further address direct members who meet or come to meet the AMA's exclusionary criteria:

- First, the AMA Division of Membership has instituted an additional procedure to screen renewing direct members who have been the subject of disciplinary actions. Full disclosure of the nature of the action is now required from both initial and renewal direct membership applicants. In the vast majority of cases, these procedures will allow the AMA to restrict membership to physicians who meet the Association's standards of ethics, competence and professionalism. Questionable applications, such as those involving sanctions of intermediate seriousness or issues of rehabilitation, will be referred to the Council on Ethical and Judicial Affairs for dispositive action.

- Second, the AMA is monitoring periodically those direct members who have had serious disciplinary actions reported and will immediately expel those

meeting the AMA's criteria for automatic expulsion described above. The Rules of the Council on Ethical and Judicial Affairs outline the due process to be afforded these physicians, and provide for fair notice, and the opportunity to be heard and present any special circumstances that may weigh against taking this drastic action.

3. State Society Members

Significantly, the majority of physicians reported to the AMA as having had some disciplinary action taken against them are not members of any medical professional society. Nevertheless, a substantial number are included in the membership rolls of one or more state societies and, pursuant to AMA Bylaws, become constituent members of the AMA through "certification" by the secretary of a state society. State societies have the initial responsibility to review and sanction those constituent members who are found to have engaged in professional misconduct. Hence, it is imperative that the AMA work with local societies to address this population of physicians.

The following program has not been put into place:

- The AMA Division of Survey and Data Resources and its Department of Physician Credentials and Qualifications are expanding current operations to include periodic transmittal of physician disciplinary data to state, local and specialty societies and specialty boards. Currently, the AMA provides information of this nature only to state licensing boards, through the mechanism of "Licensure Alert Letters," instituted by the AMA in 1985. This further expansion of the AMA's operations will serve to close a hole in the existing network for disseminating this information to all interested organizations.

- The AMA also will develop a monograph to assist state and local societies in performing membership review and disciplinary activities. Mechanisms similar to those implemented by the AMA for screening physicians at membership entry levels will be delineated, draft bylaw provisions reviewed, and the legal constraints and guidelines applicable in doing effective disciplinary activity discussed. The role of the federal "clearinghouse" activity mandated by the Health Care Quality Improvement Act of 1986 also will be analyzed.

- If a state society has been afforded the opportunity but has failed to take the necessary action to exclude a physician who has clearly violated his or her professional or ethical obligations, said physician will be referred to the Council on Ethical and Judicial Affairs for direct action to exclude him or her from membership in the AMA. These physicians will be expelled when warranted, pursuant to Council rules and AMA Bylaw provisions applicable to constituent members. The Council's rules again provide for full notice to the physician of the reasons for taking the action as well as the opportunity for a hearing.

Through these activities, the American Medical Association commits to working with local and specialty societies in an ongoing effort to supply them with current information and enhance their ability to exclude as members those physicians who are unethical or who do not render competent medical care. The combination of this assistance effort and the AMA's program for screening and monitoring its direct members should provide an effective response to the quality of care concerns underlying Report QQ of the Board of Trustees (A-86).

AMA kicks out 31 doctors

Sun Times 3/16

By Howard Wolinsky

Cracking down on unethical practices

In an unprecedented move, the American Medical Association is systematically kicking out doctors who have been convicted of felonies, sold illegal drugs or proved unethical in other ways.

In the first purge, the AMA has revoked memberships of 31 physicians, said Kirk Johnson, general counsel for the 291,000-member association.

"Being an AMA member ought to give patients a clear indication that this is a good physician," he said.

He said loss of AMA membership can have serious consequences.

For instance, in some states, including Illinois, expelled doctors can't buy malpractice insurance from state medical associations. Further, loss of membership will be reported to a soon to be launched national data bank that hospitals will be required to check before granting admitting privileges.

The first doctors booted out in most cases had lost their medical licenses for illegal activities, including drug abuse, insurance fraud, theft and assault. The Chicago-based AMA gleaned the names of the unethical physicians from a list provided by the Federation of State Medical Boards.

One doctor is from the Chicago area and two are from Downstate. The AMA is withholding the names.

Dr. Sidney Wolfe, executive director of Public Citizen Health Research Group, a consumer organization that has studied physician discipline, was skeptical of how exhaustive the AMA effort was because so few doctors turned up.

Wolfe added, however, "Doing something is better than doing nothing."

Johnson contended that doctors who join professional groups are less likely to be in trouble for unethical or illegal behavior.

In the past, enforcement of the AMA's code of ethics was "not strong," Johnson said. Unethical doctors were quietly not invited to rejoin the AMA.

Johnson said doctors can appeal the decisions in 60 days. He said several physicians have notified the AMA that it "will be hearing from their attorneys."

Wolfe criticized the AMA because two of the 31 newly purged doctors actually had lost their licenses in 1982.

Johnson said: "The reason we [started this program] was as much as anything a symbolic gesture. But we did want to send a signal to [local medical societies] that the AMA was not afraid of expelling members."

Dr. Eugene Johnsen, president of the Illinois State Medical Society, said, "It's good the AMA is getting involved. By and large, the AMA has depended on the state and county medical societies to take care of these problems."

He said the AMA's support will give county and state medical societies more courage to move against unethical doctors. Local groups are fearful of suits for defamation and violation of anti-trust laws.

Mr. COYNE. Thank you, Dr. Todd.
Mr. Herman.

STATEMENT OF RUSS M. HERMAN, PRESIDENT, ASSOCIATION OF TRIAL LAWYERS OF AMERICA

Mr. HERMAN. Good morning, Mr. Chairman, members of the committee, and distinguished panelists. My name is Russ Herman. I am an attorney from New Orleans, La. This year I represent 65,000 trial lawyers who represent injured persons and small businesses.

I want to deal with the facts. I was once told that there is nothing more horrible to see than the murder of a beautiful theory by an assault of the facts. I hope, and I would like to ask, that my written remarks be included in the record; at page 2 of those remarks there is an error. Three lines from the bottom, the year date should be changed from 1989 to 1984.

What I have heard and what I understand is that there is a growing concern among all Americans, regarding the cost of health care in this society. The last objective measurement of those costs was in 1987; it was $500 billion. The cost of medical liability insurance premiums was $3.8 billion, less than seven-tenths of 1 percent. That is a fact. Now, you can take away people's rights under tort reform, and, remember, every time that you enact so-called tort reform, you are removing a right that exists of an injured person. If you are capping damages, you are saying to one person that has been injured: You are going to be entitled to less than other people in society are entitled to as compensation for their injuries. So every time that you "reform," you remove a right, but you are not going to get at the cost by removing rights.

I believe there may be merit in every proposal. Every proposal ought to be examined. It ought to be looked at. Indeed, Pericles, the father of our democracy, said: "We differ from other States regarding those who hold aloof from public debate, not as merely quiet but as useless. But we discuss all matters carefully. So that an act is not fore-doomed to failure."

What are some facts which have not been investigated? I want to cite to you statements, investigations, not investigations done by lawyers—indeed, generally done by journalists who don't agree with lawyers most of the time. There is no question that the senior citizens and children of this country are mostly the victims by numbers of increasing medical negligence. August 13, 1989, the AP says increased cost is caused by doctor-owned laboratories which reap lavish profits. The Wall Street Journal isn't a bar review. Has the GAO investigated why, according to the Journal, in some laboratories an x ray costs $17 and in other labs it costs $300? It is not because some physician has committed negligence on an innocent adult, 75 years old, who has brought suit. The labs increasingly are owned by doctors, and there is an in-built conflict of interest. The doctors refer their patients to their own laboratories. Has that cost been investigated?

January 9, 1990, Financial World, a business magazine, not a legal publication, reports that $650 billion in medical costs are wasted a year. What do they conclude? That there are excessive

tests and excessive operations. Not out of defensive medicine but, as a doctor from Stanford University—just ranked as the second best medical school in the country—has found and as he has reported, there are more surgeons than there are operations. So the surgeons are overtreating. Now, that is not caused by the 75-year-old victim of medical negligence who brings a lawsuit. If there is a glut of surgeons in this country, it ought to be studied. Where is that reported? November 7, 1989, in the New York Times. There is no study going on relative to the number of surgeons in this country as compared with the actual need for surgeries.

On January 10, less than 3 months ago, the Wall Street Journal reported on the hospital boom in this country. There is no GAO investigation of the over-bedded hospitals in this country; some hospitals are buying up medical practices wholesale in order to have referral sources to fill hospital beds.

Now, the 7-year-old child who has a ruptured appendix, where the signs and symptoms are ignored, and whose parents bring a claim for medical negligence, is not responsible for the cost of the over-bedding of hospitals in this country. Yet there is no study directed at that.

What is happening? The victim is being blamed for the cost. And what do you say to the victim? Eliminate the right to trial by jury. The Magna Carta in 1215, the only thing mentioned twice, the only basic right, is the right to jury trial. In the great debate between Hamilton and Jefferson, as reported in the Federalist Papers, there was debate over the right to have all matters decided by juries. And Jefferson said the right to jury trial was more important than the right to vote, and every system proposed, every tort system, takes away initially the right of that injured adult or that injured child to a jury trial.

Now, we lawyers have blame, too. It costs us $15,000 most of the time to get expert testimony. Is there any investigation as to why it is so difficult and so expensive? No. And yet we have two reports, one from the Journal of the American Medical Association a year ago, May 26, 1989, in which a study conducted by physicians of medical students was reported in which 40 percent said they would lie—they would lie—to cover up medical negligence in a hospital. Incident reports, infectious disease reports, peer reviews are not open. People don't go to lawyers when they have been told, gee, it is not my fault, this is due to some disease, this is due to this problem. How do you get a lawyer? How do you know you even have a right to recourse, and how is arbitration going to help when you don't even require that the patient own his own hospital record, the original, have access to it, have access to a peer review report or an incident report?

And what is the proposed solution again? Go to a panel where three physicians will judge whether or not a physician injured the third party. Why, the English rejected that in 1625 with the statement that a fox should not sit at the trial of the goose. We lawyers, we physicians, we have special responsibilities in society. This is a capitalistic democracy. What that means is that we take risk for what we earn. Just like a business person takes risk, and part of the risk is that when you injure somebody, you answer for your

fault, and you answer the same way that everybody else does in society.

We doctors and we lawyers are in the upper 1 percent of the educated people on the earth. We are in the upper 1 percent of the earners on earth. We ought not to be afforded, under American justice, special privileges. Make no mistake about it, I am proud to be a lawyer, and I am proud to be an American under this system, which is the best system. Why? Because in my profession, it is unethical for me to limit my liability as to the innocent client that I harm. And it is unethical for me not to disclose clients that I have injured them.

Now, I say to you that it is true that we have the highest quality of medical care, and that 10 percent of the physicians in this country are responsible for 80 percent of the negligence. Studies in Florida and Pennsylvania confirm that. I am not here to bash doctors. I owe my life, literally, to doctors. I represent doctors. But I think that doctors are human beings, as are lawyers. We all make mistakes.

Most respectfully, I conclude with this: Thomas Jefferson was right.

Thank you.

[The statement and attachments of Mr. Herman follow:]

STATEMENT OF RUSS HERMAN, PRESIDENT, ASSOCIATION OF TRIAL LAWYERS OF AMERICA

Mr. Chairman and members of the Subcommittee, the Association of Trial Lawyers of America (ATLA) deeply appreciates the invitation to participate in this discussion; I am reluctant, however, to state that ATLA welcomes the discussion. Surely, there is no need for additional rhetoric. If, however, this Committee can begin the process of turning the rhetoric into more thoughtful, more reasoned and more accurate discussion, it will have performed an enormously useful service.

Mr. Chairman, let's not be distracted by the tumult and the shouting. There is no need to be; there is reliable, empirical data and there is lots of it. Careful examination of that data makes a compelling case: the cause of the medical malpractice "crisis," regrettably, is medical malpractice -- negligent doctors committing preventable errors. Beyond that, we know now also that very few incidents of malpractice actually result in a lawsuit, much less in a successful lawsuit or even a voluntarily settled claim.

The members of this Committee undoubtedly hear all the time that the number of medical malpractice claims is increasing. That is an assertion repeated so often, and so stridently, that it has become a regular staple of the debate; it is accepted as true. It is not. Unfortunately, however, the starting point of this discussion seems to be not one, but two false premises: that there is an ever increasing number of malpractice claims and that the size of malpractice awards is skyrocketing.

When the very underpinning of the debate is false, public policy makers understandably have great difficulty making rational choices.

The facts are these: there is no evidence that claim frequency has changed measurably in recent years, instead it has leveled off or more probably, actually declined. Moreover, when measured against the increase in the number of doctors, even the increase in the raw number of claims in the early 1980's is not dramatic.

Let us review some of the real evidence.

Earlier this year, the Health Department of the State of New York released an extensive examination of malpractice issues conducted for it by the Harvard University Medical Practice Study. That research -- described as the most comprehensive, empirical study of medical malpractice ever undertaken -- found that medical negligence is responsible for the deaths of thousands of patients in New York hospitals each year and that it injures many more.

The Harvard researchers reviewed the records of more than 30,000 patients admitted to 51 New York hospitals in 1984. The sample was carefully selected to represent state population in terms of race, payer class, age, sex, and type of hospital (urban, rural, teaching and non-teaching, profit and non-profit, municipal and non-municipal). In addition to its dramatic findings relating to the incidence of malpractice, the Harvard study also concluded that only a very small fraction of people injured through negligence ever file malpractice claims.

Briefly, Mr. Chairman, (and we will be pleased to provide the entire study for the record if that is the wish of the Committee), based on its research, the Harvard group estimated that nearly 99,000 patients -- approximately 3.7 percent of those hospitalized in New York during 1989 -- experienced injury, or what the Study termed an "adverse event," as a result of their medical treatment. Just over a quarter of those, or about 27,000, adverse events were caused by negligence. In contrast, the Study estimated that a range of only 3,000 to 3,900 claims were ever filed; and of the more than 30,000 patients whose records were reviewed, only 47 filed malpractice claims.

On a statewide basis, it was estimated that only about 1 in 8 victims of medical negligence files a lawsuit in New York and far fewer than that -- about 1 in 16 -- ever receives compensation.

Those figures should not surprise us. They corroborate other research done earlier, most notably Patricia Danzon's study done for the Rand Corporation in 1983. According to Professor Danzon's Economic Analysis of the Medical Malpractice

System: "At most, one in ten incidents of malpractice results in a claim, and, of these, less than half, or one in 25, receive payment."

Couple the Danzon estimate (that only one in ten malpractice events results in a claim) with the estimate of the American Medical Association that in 1983 there were roughly 42,000 claims. That means that as many as 420,000 incidents of malpractice occurred. Even if we were to grant what we know is not so, that somehow the number of claims was substantially higher or was underestimated, even by as much as 50 percent, and that two in ten incidents resulted in a claim; that still means for 1983, as an example, that there were 210,000 incidents of malpractice. That figure, surely low, still represents one event for every 2 1/2 doctors in the country. (The Statistical Abstract of the United States showed 542,000 physicians in the U.S. in 1983). A final note regarding 1983: That year, the Dean of the Yale School of Medicine, estimated that nearly 300,000 patients were harmed by the negligent practice of medicine. Whatever the figure -- 200,000 or 300,000 or 400,000 -- the reality is that by every recognized study, 80 to 90 percent or more of that never results in a claim, let alone in payment.

Nor is it irrelevant to point out, Mr. Chairman, that during the 1970's and 1980's the number of doctors in the United States was rising significantly. If there were malpractice claims filed in larger numbers, that fact cannot be cited in a vacuum. In 1975, there were 409,000 physicians is this country. Eight years later, in 1983, there were 542,000. Claims per 100 doctors did not rise dramatically during those years, though we are the first to point out that such a statistic itself is difficult to measure. In large part, that is because no one even agrees on a standard definition of the word "claim" as used in this context. In 1986, the Orlando Sentinel examined 2,755 medical malpractice claims filed in Florida during 1984. The newspaper's investigation revealed that more than 1,000 of them amounted to nothing more than a patient seeking further information and a doctor consequently notifying his insurance carrier. According to the Sentinel report, statements regarding the number of malpractice claims in Florida may have been inflated by an average of 40 percent per year.

It is worth examining a comprehensive study undertaken by the Minnesota Insurance Department of all closed claims filed in Minnesota, North Dakota and South Dakota over a recent six-year period. That study found not only "that claim frequency has not changed measurably in the last six years," not only that "(t)he 1987 frequency rate is actually less than the 1983 rate" but also that "(a)verage payments actually appeared to be decreasing over the period of study." That finding should not surprise us, nor is it atypical of what is happening elsewhere around the country. Consider the November, 1989 headline in the Miami Herald: Juries Give Smaller, Fewer Malpractice Awards. Or this headline a week later in the Journal of Commerce: Malpractice Crisis Fades with Smaller, Fewer Awards.

Other state studies have yielded similar conclusions.

A 1989 report submitted to the Legislative Council for the state of Maine found that the frequency of claims had fallen dramatically and that the average claim only amounted to $13,500. The report concluded that "from the data, it is apparent that the frequency, severity, and losses as a percentage of income do not indicate that the liability insurance problem in Maine is out of control."

In Michigan, a 1989 report by the state Insurance Bureau similarly concluded that fears of an insurance crisis into the 1990's were unfounded. Claims had begun to drop in 1987 and 1988 and insurance rates had leveled.

If, then, the size of awards appears to be coming down (rather than "skyrocketing" as some have claimed), it is worth asking also: just how large are these awards to begin with? The real facts reveal a) that they are very modest and b) that any increase that occurred in earlier years is not excessive when the escalating cost of health care generally is considered -- medical expenses often comprise 25 percent or more of the costs of awards. (In short, the increases merely reflect inflation and societal changes such as increased life expectancy and earning capability.) The truly striking figures, though, are these: In a 1987 study examining medical malpractice claims closed in 1984, the GAO found that the median indemnity payment for all claims was only $18,000. Some 69 percent of the claimants received less than $50,000; fewer than one percent

received $1 million or more. Contrast that to the 9 percent which the GAO found received under $1,000.

The Minnesota Insurance Study (3 states over six years) found the average payment for all closed medical malpractice claims to be only $14,542; the median was zero. Even for the 27 percent of claims closed with payment, the average pay-out was $54,629; the median only $15,000. Only 0.1 percent of the claims that closed with payment involved damages exceeding $1 million. Only 4 percent of the claims receiving payment exceeded $100,000.

Mr. Chairman, something else needs to be said about medical malpractice. It concerns an issue that receives far too little attention but it may hold a key to solving some of the real problems.

ATLA is not shy about stating its position that there is far more malpractice than is ever detected, or that gets reported, but we know also that a small number of doctors are responsible for a disproportionately large share of claims paid. If the medical profession more effectively disciplined its few bad doctors, malpractice costs could be cut dramatically, perhaps in half.

The data is not merely striking, it is astonishing. Let's examine four large states: Florida, Illinois, Pennsylvania and Texas.

In Florida, several published studies are revealing. One shows that for the period 1975 through 1984, 3 percent of Florida physicians accounted for 45 percent of the money paid out to malpractice victims in the state. Another study, conducted by the Florida Academic Task Force for Review of the Insurance and Tort System, found that for the period 1975-1986, 4 percent of the doctors were responsible for more than 42 percent of the paid claims. And an earlier closed claims study in Florida actually revealed that less than one percent of the physicians accounted for 24 percent of the malpractice claims paid over a seven-year period.

In Illinois, similar findings: A 1987 study revealed that 2 percent of all physicians practicing in Cook County were defendants in 36 percent of the medical malpractice litigation filed over the previous fourteen years. In Pennsylvania, as of 1985, one percent of physicians had accounted for 25 percent of the losses paid by a state excess liability fund since its creation in 1976. Finally, data compiled from reports by the Texas State Board of Medical Examiners found that fewer than 8 percent of all practicing physicians in that state accounted for 65 percent of the malpractice claims filed between 1975 and 1987.

In the face of all of this, why are legislatures being asked to limit the rights of innocent victims? Why is it that those being injured by medical negligence are the ones being punished? Would it not make more sense and would it not be far more just for state medical boards to more aggressively police doctors and more responsibly protect the public? Surely, the medical profession is capable of a better job of self discipline than the frankly shameful performance it has produced to date.

In 1984, as an example, there were actually nine states and the District of Columbia which took serious disciplinary action against zero doctors. That same study, published in 1987, revealed that nationwide, fewer than 1.5 doctors per 1,000 -- less than one hundredth of one percent! -- were the subject of any serious disciplinary action. The New York Times reported in 1986 that of the nation's 553,000 licensed physicians, only 235 had their licenses suspended during the previous year, only 491 -- nationwide -- were put on probation. Last year, the Wall Street Journal reported similar low numbers for 1987 based on data collected by the Federation of State Medical Boards in Fort Worth, Texas.

At the same time, the Washington Post was reporting that "an estimated 3 to 5 percent of the nation's . . . physicians are thought to be incompetent or impaired by alcohol or drug abuse," and the Journal of the American Medical Association itself reported a 1987 study which found that 11 percent of medical students met criteria for excessive drinking during at least one six-month period and identified 18 percent as

alcohol abusers. None of this means that doctors as a class are irresponsible, or that all doctors or most doctors are incompetent. Much to the contrary. But the record or more accurately, non-record, of discipline by the profession against its own members is intolerable.

Mr. Chairman, there is another commonly stated and widely believed myth that the fear of litigation has caused some physicians to conduct more tests and procedures than necessary -- a practice referred to as "defensive medicine." It is often blamed for adding to the overall cost of medical care. Defensive medicine, it is said, raises not only the cost of health care, it increases risk to patients.
Those sentiments, in fact, were repeated by the distinguished chair of the Subcommittee in the news release announcing this hearing.

Like other assertions in the malpractice debate, it is repeated so often that it becomes a truth not because it is true but because everybody repeats it, so it must be true.

It isn't true! What is called "defensive medicine" by some doctors and most commentators is simply "quality care," the kind of care we all hope to get when we are treated by a good doctor.

If organized medicine now opposes "defensive medicine" it did not always do so. The AMA Journal in 1975 said that "defensive driving" is a good practice for motorists and that it appeared that "defensive medicine" is essentially beneficial to patients.

To the extent that "defensive medicine" means "extra care medicine" it should not be discouraged. In fact most insurance carriers encourage it. Second opinions have become a fact of medical life.

If the practice of "defensive medicine" constitutes unnecessary treatment, then it is a violation of the ethical code of the medical profession and should be punished. I would hope that the overwhelming number of physicians would not violate their ethical code.

But if they do, you can bet it is not because of the threat of lawsuits, it is more likely to be motivated by plain old fashioned greed. Approximately $1 out of every $3 of the nation's health care bill is for tests.

A noted health care economist at Princeton University, Uwe Reinhardt has said, "Doctors are finding the machines to be excellent money makers, the profits are outrageous." Each new piece of equipment can make many thousands of dollars a year.

It is to be hoped that modern technology has pushed medicine closer to science, that each new machine has opened wider the windows of diagnostic ability and is therefore to be embraced, and welcomed, for it can assist doctors to more accurately diagnose illness and in the long run provide better medical treatment. This will result ultimately in a savings of money. Earlier diagnosis means better chances at cures and shorter illnesses. But we must state also that even if it doesn't save money, the value of careful medicine is worth the price.

Let's talk for a moment about medical malpractice insurance. Most of you hear it stated frequently that malpractice insurance is a very unprofitable line of insurance. That is a statement recited constantly by insurers, whether doctor-owned or commercial carriers; it is cited also by physician representatives, by lawmakers and others. Yet, the General Accounting Office found in a 1987 report to Congress that malpractice insurers earned a profit in 10 of the 11 years examined at an overall rate of return estimated to be as high as 15.3%. How can the discrepancy between the perception of a money-losing operation and reality be so enormous?

The press release announcing this hearing offers a useful example with which to begin the admittedly complicated task of examining the intricacies of medical

malpractice insurance. The press release states "insurers generally pay more in losses that they earn in premiums."

That is an outright misstatement -- the Committee has been victimized by insurance industry double speak which has been successfully used to suggest that "incurred losses" actually equate to losses paid. By its own unique accounting practices, incurred losses largely represent reserves which are retained by the insurers to earn incredible sums of investment income which they do not report as part of their underwriting results and they are not reflected in the performance of the medical malpractice insurance subline. A loss is simply not a loss in the insurance business- repeat that 1000 times and you are on the way to becoming de-programmed.

Certain lines of insurance, however, such as any professional lines like malpractice, have what insurers refer to as long tails. The tail arises because in malpractice it can take many years for a claim to become known (the patient doesn't know a surgical device has been left in the stomach during a previous operation or a minor may be involved which can, depending on state law, postpone the running of the statute of limitations). In addition, medical claims take longer to investigate and prepare for trial; they often involve complicated pretrial investigation. Because of the long tail and the fear of inflationary trends, insurers set aside large reserves in lines like medical malpractice, which in turn produce a tremendous amount of investment income for the insurer. And because these reserves are on hand for literally decades, the insurer can earn a fantastic amount of investment income by investing those assets.

Since 1975, medical malpractice has been reported as a separate line of insurance. According to figures from a specially designed state-by-state data base of the 100 largest insurers in each state which ATLA has obtained from A.M. Best, over the 10-year period 1979-1988 insurers have earned direct premiums of $26.2 billion for malpractice coverage but only paid out actual losses of $11.9 billion for the same period. The average paid loss ratio for all states over the same period was 45.65% (see Exhibit I). In some states, the ten year paid loss ratio was as low as 21%. In 1988, the data base indicates premiums taken in of $4.8 billion and paid losses of $2.1 billion, a 43.72% paid loss ratio. I should emphasize the data base does not purport to represent all insurance written, but we believe it to be very representative.

In 1988, according to Best's Loss Reserve Development report, malpractice insurers had $16.5 billion in reserves at year end. If we estimate about a 10% rate of return, which is a safe, conservative estimate, that would result in investment income of $1.65 billion for one year on a line of insurance that takes up to 10 years to pay out claims incurred in any given year. In other words, insurers nearly earn back in investment income on medical malpractice reserves what they have actually paid out in claims for a year. Yet they still continue year after year to take in and reserve huge sums to be invested for each successive year. What is the justification for setting rates so high to support this investment return? The real answer, of course, is there is no justification for it. If underwriting results were the only criteria, perhaps such rates could be justified -- but in medical malpractice, underwriting performance alone simply distorts the most critical income factor (investment income) for this line of insurance.

To help understand the significance of reserves on insurance an April 1st article in the N.Y. Times is worth examining. The article notes that the St. Paul group, the nation's largest commercial malpractice insurer had changed its previous estimates of reserves by $14.5 million in 1988 and added the funds to its surplus account. The article then noted that one stock analyst had predicted the trend would continue. "Trend? More like a tidal wave. A whopping $250 million was released from reserves for old claims and moved to revenues" for 1989 noted the Times. What does that mean? It means St. Paul admitted it over-reserved for that time period AND it earned considerably investment income on that money in doing so. Yet the doctors whose premiums years ago contributed to those reserves do not receive any benefit from this change. Any benefit the insurer chooses to pass back, and it is highly doubtful that any money is passed back to the policyholder, is typically given to current policyholders who are not necessarily the doctors who contributed to the original reserve account.

What seems to escape the attention of many observers is that the real NEWS concerning malpractice experience in the states over the last few years really is a good news story. For example, St. Paul, the largest medical malpractice underwriter in the U.S., and others have announced rate reductions in about 34 states. A sample list of those states is attached for your review as Exhibit II.

It is important to put the scope of the medical malpractice situation in context. As the GAO Study found, the so-called malpractice crisis is really an insurance problem which affects only a few specialties in a few geographic areas.

It is worth noting to the committee why certain specialties are adversely affected by malpractice; this occurs because of the way rates are set for physician specialties. As specialization has increased, insurers have learned to precisely follow the risk associated with that specialty and priced their product accordingly. This results in a severe restraint in the operation of the law of big numbers, a primary insurance principle. By putting all neurosurgeons in single state risk pools, insurers succeed in assessing risk for that type of doctor, but in a small state, the pool of neurosurgeons may be so small that the pool cannot easily absorb the impact of the statistically few but predictable severe injury cases that will occur; and thus speciality rates need to be maintained at high levels.

In addition, we invite the committee's attention to the fact that in most states malpractice insurance still is not experience-rated, i.e., a doctor's own loss experience and claim payment record does not impact his or her own rates. This is not acceptable- if car insurance can be factored to include a drivers own claims payment history, surely physicians can be similarly rated.

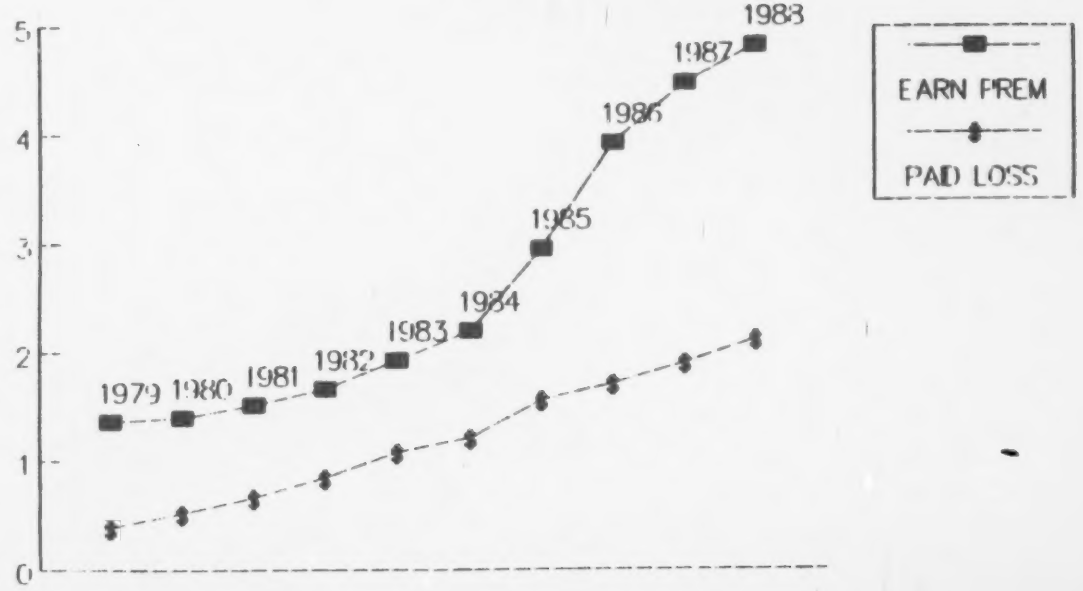
Finally, Mr. Chairman if these hearings represent an effort to broach the subject of medical negligence as part of a larger effort to lower the nation's health care bill, I am deeply troubled. I am troubled in part because I realize to some extent that I and my profession have failed.

If my profession has not been able to convince the national legislature that medical malpractice is in no way whatsoever connected with the larger issue of the high cost of health care in this country, then I have to admit some degree of responsibility. The proposition that the cost of repairing the damage an innocent victim of misconduct suffers is to be considered as somehow contributing to the high cost of delivering health care in this country is almost astounding. Estimates of the annual cost of health care in the U.S exceeded $500 billion in 1987, the most recent year for which HHS has information. The cost of the malpractice system in the U.S. for 1987 as measured by net premiums earned by underwriters amounted to $3.8 billion dollars-- that's less than 0.777% of the health care costs in the U.S. Seven tenths of 1% for the cost of repairing innocent victims for unwanted medical injuries does not seem too much to me. And remember that the 0.777% delivers a system of justice that has led to a host of reforms in medical practice which have resulted in greater safety.

The best way to reduce malpractice suits is to reduce the incidence of malpractice, not to eliminate the rights of innocent victims.

MEDICAL MALPRACTICE PREMIUMS

U.S. TOTAL 1979--1988



(Billions)

EXHIBIT I

EXHIBIT II

MEDICAL MALPRACTICE RATE CUTS

St. Paul, the nation's largest medical liability insurer, reduced medical malpractice rates in 34 states, by an average of 14% nationwide.
SOURCE: Wall Street Journal, April 28, 1989

The following is a sampling of states where medical malpractice premiums have been reduced:

ARKANSAS
Rate cut: 5.25%
Insurer: St. Paul Fire and Marine
Source: Arkansas Business, May 22, 1989 -

GEORGIA
Rate cut: 18%
Insurer: St. Paul Fire and Marine
Source: Atlanta Journal-Constitution, April 21, 1989

IOWA
Rate cut: 25.7%
Insurer: St. Paul Fire and Marine
Source: Des Moines Register, June 15, 1989

KANSAS
Rate cut: 7.4%
Insurer: St. Paul Fire and Marine
Source: Journal of Commerce, June, 14, 1989

MAINE
Rate cut: 21.7%
Insurer: St. Paul Fire and Marine
Source: Best's Insurance Management Reports, May 30, 1989

MARYLAND
Rate cut: 20%
Insurer: Medical Mutual Liability Society of Maryland
Source: Liability Week, October, 23, 1989

MINNESOTA
Rate cut: 25%
Insurer: St. Paul Fire and Marine
Source: Business Insurance, April 17, 1989

NEW YORK
Rate cut: No increase for first time in years.
Insurer: Decision made by Insurance Commissioner Corcoran
Source: Journal of Commerce, July 7, 1989

NORTH CAROLINA
Rate cut: 20%
Insurer: St. Paul Fire and Marine
Source: Journal of Commerce, June 14, 1989

VIRGINIA
Rate cut: 22.4%
Insurer: St. Paul Fire and Marine
Source: Best's Insurance Management Reports, September, 25, 1989

WASHINGTON
Rate cut: 9.1%
Insurer: The Doctor's Company
Source: Liability Week, October 16, 1989

Mr. COYNE. Thank you, Mr. Herman.
The next witness is Mr. Amsden.

STATEMENT OF PERRY AMSDEN, BREWER, MAINE, AARP/VOTE CONGRESSIONAL DISTRICT COORDINATOR, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. AMSDEN. Good morning. My name is Perry Amsden. I am the AARP/VOTE 2nd congressional district coordinator in the State of Maine, and I live in the small city of Brewer. I am pleased to be here on behalf of AARP this morning to present a consumer—specifically, a Medicare beneficiary—perspective on medical malpractice. AARP commends the subcommittee for focusing attention on this important issue.

AARP believes that there are three components of the medical malpractice issue. One is the medical negligence issue. The second is the liability insurance issue. Third is the tort system reform.

Much of the discussion of the malpractice issue centers on its legal and insurance aspects. Unfortunately, this often tends to obscure the most important fact: that medical malpractice underlies much of the problem.

The recent Harvard Medical Practice Study reviewed a sample of hospital discharges to see what percentage were "adverse events" or unintended injuries through medical management. The study also looked at what percent of these were caused by fault or negligence and what percent led to claims or suits.

Of special concern to AARP is the study's finding that persons over 65 had a much higher incidence of adverse events than others, and that a higher proportion resulted from negligence. Therefore, the first and most important step in any approach to the malpractice problem should be enhanced quality controls, identification of negligent providers, and risk management to lower incidence of negligent care.

AARP believes that there are a number of approaches that must be taken at the State and Federal levels. Some of these could include: strengthening physician and health care facility licensure requirements; publication of critical information by the national data bank on physician performance; and research the area of medical effectiveness. In addition, the legislation H.R. 4464 builds on Medicare's traditional responsibilities for setting standards for providers participating in Medicare.

This second component of AARP's recommendation centers on insurance industry reforms. There is still little public understanding of the coverage and rating practices of liability insurers, and that leads to periods of great concern about both the price and availability of insurance.

States remain the focus of activity for any reforms in the liability insurance market. AARP believes that State insurance departments should undertake a number of efforts in this area. Specific recommendations are included in the written statement that I have provided the committee.

If, however, State insurance commissioners do not adequately oversee the collection of liability insurance data so that informed judgments can be made about the adequacy of insurance coverage,

administrative practices, and premium levels, then we see no alternative but Federal action to address this problem.

The third and final component of our proposed reform is the legal system. A careful balance between conflicting objectives must be maintained. On the one hand, all patients subjected to negligent treatment must have comparable access to compensation. On the other hand, we need to discourage frivolous suits or a system like we have today in which legal and other overhead costs consume the majority of a patient's compensation.

AARP believes that a number of State actions addressing the tort system are an appropriate approach to the malpractice problem. Some of these include voluntary arbitration for large claims, hospital liability for injuries resulting from medical malpractice occurring in the facility, and structured settlements.

Mr. Chairman, as you consider this issue, it is vitally important that we learn more about the problem and potential solutions. We believe that additional research of the type exemplified in the Harvard study should be performed to precisely document the incidence of medical malpractice. This type of research is within the purview of the new Agency for Health Care Policy and Research.

In addition, research and evaluations should examine the effects of some of the State actions taken to date to revise insurance law and tort law.

Mr. Chairman, I appreciate the opportunity to share the views of AARP with you on this issue, and we look forward to working closely with you on a variety of Medicare issues. Thank you.

[The statement of Mr. Amsden follows:]

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STATEMENT OF PERRY AMSDEN, MAINE AARP/VOTE, AMERICAN ASSOCIATION OF RETIRED PERSONS

Introduction

Good afternoon. My name is Perry Amsden. I am the AARP/VOTE Congressional District Coordinator in Brewer, Maine. I am pleased to be here this afternoon on behalf of the American Association of Retired Persons to discuss the beneficiary's perspective on the medical malpractice issue.

My remarks today center on what we view as the three components of the medical malpractice issue: 1) medical negligence; 2) liability insurance; and 3) tort system reforms.

Background

This Subcommittee is well aware of the fact that issues related to medical malpractice and the professional liability insurance market have been with us for many years. Attention to these issues has been heightened in a fairly cyclical pattern when the price of liability insurance rises, and when problems in the availability of insurance appear to threaten patient access to certain types of services.

As your other witnesses have mentioned, there has recently been just such a period of rapid price increases and problems in the availability of liability insurance, although the most current data indicate that the frequency of claims has decreased and that the premium increases may be leveling off. AARP hopes that this provides an opportunity to look carefully at the various elements of the malpractice problem, and commends the Subcommittee for undertaking this effort.

AARP believes that it will be necessary to develop a balanced approach that deals with the three components of the medical malpractice problem: medical negligence, the liability insurance market, and the legal system. We can look at each of these areas in turn to identify potential solutions.

Medical Negligence

Much of the conventional discussion of the malpractice problem centers on the legal and insurance aspects. Public attention to the issue focuses largely on the specter of an overly litigious society and the unending legal and financial battles among doctors, lawyers, insurers, and patients.

That discussion tends to obscure the most important fact -- that medical malpractice underlies much of this problem. The recent Harvard Medical Practice Study conducted in New York reviewed a sample of 31,000 hospital discharges to develop an estimate of the number and percentage of "adverse events." These are defined as an unintended injury caused by medical management rather than by the disease process which is sufficiently serious to lead to prolonged hospitalization, or temporary or permanent impairment or disability. Further, the researchers determined the percentage of adverse events caused by fault or negligence and the percentage that led to claims or suits.

Of special concern to AARP is the study's finding that persons over 65 years of age had a much higher incidence of adverse events, even when the results were standardized to control for the differences in underlying diseases that occur among different age groups. For the elderly, 5.7 percent of the cases reviewed resulted in adverse events, nearly double the 3.7 percent adverse event rate for the total population. In addition, a higher portion of the adverse events for the elderly resulted from negligence.

The study also found that among patients with adverse events due to medical negligence, older Americans and those with relatively mild impairments were the least likely to purse litigation. The authors note that the reason is that legal awards are a function of the degree of disability, the level of lost wages, and the remaining life expectancy of the injured patient. The authors also note that:

> "We do not mean to suggest that these injuries are acceptable or should not be compensated, but simply that the present-day market for legal services tends to exclude these claims of limited financial value from litigation." [page 7-37, 7-38, Harvard Medical Practice Study.]

These results suggest that there are unreported problems of medical negligence, especially among the elderly.

Thus, the first and most important step in any approach to the malpractice problem should be enhanced quality controls, identification of negligent providers, and risk management to lower the actual incidence of negligent care. AARP believes that there are a number of approaches that must be taken at the state and federal levels.

First, there are steps that should be taken by the states to help identify and discipline substandard providers. For example, health regulatory boards should be required to disclose publicly all serious disciplinary actions. Physician and health care facility licensure requirements should be strengthened. Hospital control of admitting privileges based on quality measures should be expanded. Knowledgeable consumers should be placed on all health and long-term care licensure boards, and those boards should have adequate funding and authority to investigate and discipline substandard providers.

Federally, the National Data Bank on Physician Performance, enacted in 1986, is now scheduled for implementation in September, 1990. All adverse actions that limit clinical privileges, and malpractice disputes that result in settlements or court orders, must be reported to the data bank. Hospitals, state licensure bodies, and others will have access to that data bank, and hospitals in particular will have to query the system in their initial and renewal credential activities in order to gain limited immunity in subsequent liability suits.

AARP has supported implementation of this program and urges that there be no further delay in its implementation. The Association advocates publication of periodic reports on aggregate statistical information. In addition, AARP recommends publication of lists of specific hospitals and licensure boards that are known to be out of compliance with the obligation to consult with the data bank once it is operational. Finally, AARP supports measures to coordinate and share information among Medicare contractors, PROs, and other entities with the responsibility to monitor the practice of institutions and individual providers.

AARP also strongly supports the federal effort that this Subcommittee helped shape to expand our knowledge base with more research on medical effectiveness, and to develop clinical practice guidelines for use in the health system generally, and in Medicare and Medicaid. We continue to support these initiatives and believe that this research will help generate the information and standards necessary to help assess and improve the quality of care in the future.

Mr. Chairman, H.R. 4464, the Medicare Physician Qualification Act of 1990, is intended to build on Medicare's traditional responsibilities for setting standards for providers participating in Medicare. That bill would require

recertification every seven years as a condition for physician participation in Medicare. The Secretary of Health and Human Services would set standards for such recertification and could certify that certain qualified organizations, such as certifying boards or the National Board of Medical Examiners, administer examinations that meet the standards. Further, state licensure programs meeting the Secretary's standards could be approved in lieu of private certifying entities.

Insurance Industry Reforms

The second component of AARP's recommendations centers on insurance industry reforms. There is still little public understanding of the coverage and rating practices of liability insurers. That leads to periods of great concern about both the price and availability of insurance given the upturns and downturns in what appears to be a very cyclical insurance market.

At this point, states remain the focus of activity for any reforms in the liability insurance market. AARP believes that state insurance departments should undertake a number of efforts in this area. State insurance departments should:

- conduct independent assessments of the recent rate increases;
- review more comprehensive data on underwriting and claims experience as part of an ongoing financial review of liability insurers; and
- review and approve premium increases prior to implementation.

Further, the formation of joint underwriting associations and other pooling arrangements should be encouraged in order to assure access to professional liability insurance.

If State Insurance Commissioners do not adequately oversee the important task of liability insurance data collection so that policy-makers can make informed judgments about the adequacy of insurance coverage, administrative practices, and premium levels, then we see no alternative to federal action to address this problem.

Legal Reforms

The third and final component of our proposed reforms is in the legal system, where a careful balance between conflicting objectives must be maintained. On the one hand, all patients subjected to negligent treatment must have comparable access to compensation, regardless of whether they are Medicare, Medicaid, or other patients. On the other hand, we need to discourage frivolous suits or a system, such as we have today, in which legal and other overhead costs consume the majority of the resources allocated to compensation of patients.

That is a difficult balance to achieve, but AARP believes that a number of state actions addressing the tort system are appropriate as the third component of our approach to the malpractice problem. For example, mandatory arbitration prior to entry to the courts should be required for all medical malpractice claims under $100,000, and voluntary arbitration should be encouraged for larger claims. Further, to keep prevention effective, hospitals should continue to be held liable for injuries resulting from medical malpractice that occurs within their walls.

In addition, states should consider other reforms such as structured settlements, and sliding fee scales for plaintiffs' attorneys together with limits on defendants' attorney fees. Some states may want to experiment with no-fault workers compensation approaches, while others may focus on the role of expert witnesses in establishing the standard of care applied to the issue of negligence.

Further Information Needs

Mr. Chairman, as you consider this issue, it is vitally important to assure that we learn more about the problem and potential solutions. As I mentioned earlier, this Subcommittee played a major leadership role in last year's action to authorize outcomes and effectiveness research and the development of clinical practice guidelines. An additional area of research within the purview of the new Agency for Health Care Policy and Research is the area of medical malpractice. We believe that additional research of the type exemplified in the Harvard study should be performed to document precisely the incidence of medical malpractice.

In addition, research and evaluations should examine the effects of some of the state actions taken to date to revise insurance law and tort law. This is a case in which the states have become natural laboratories. We should make sure that we learn more about what works and what does not.

Mr. Chairman, we appreciate the opportunity to share our views with you on this issue. AARP looks forward to working closely with you on a variety of Medicare issues.

Mr. COYNE. Thank you, Mr. Amsden.
Mr. Fager.

STATEMENT OF DONALD J. FAGER, CHAIRMAN, LEGISLATIVE OVERSIGHT COMMITTEE, PHYSICIAN INSURERS ASSOCIATION OF AMERICA, AND VICE PRESIDENT, MEDICAL LIABILITY MUTUAL INSURANCE CO., NEW YORK

Mr. FAGER. Thank you, Mr. Chairman.

My name is Donald Fager, and I am here on behalf of the Physician Insurers Association of America. I am a past president of that association and its legislative chairman. I am also vice president of the Medical Liability Mutual Insurance Co. of New York, which is the largest of the physician-owned companies. By profession, I am an attorney, and before I came into the insurance business, I defended doctors and hospitals in malpractice cases for almost 20 years.

The Physician Insurers Association numbers 42 companies doing business in 40 States, most of these companies were started by State medical societies in 1975 and 1976. They insure approximately 177,000 physicians, more than 50 percent of those doctors who buy insurance in private practice.

We are very grateful for your invitation to come here today and to testify on a matter of critical importance to the health care system and to the citizens of our country. That is the medical liability crisis that burdens all. It is not the crisis of availability of insurance which our companies and others solved in 1975 and 1976 when the commercial industry, for all practical purposes, abandoned the business because simply it was not profitable and it was extraordinarily volatile.

But it is a crisis of cost, of burdensome costs to physicians with premiums in the high-risk specialties in some States well above $100,000, and those costs borne ultimately, either directly or indirectly, by the public. It is a crisis—and this is the true tragedy of the medical malpractice situation, it is a crisis of access to care, for the poor and for the needy in areas which are already medically underserved. And it is a crisis of a tort system which has gone badly awry. We fully believe that people who are injured as a result of malpractice should receive prompt, equitable compensation. They are not doing that. They are not getting that under the present system.

Permit me for a minute to distinguish between the physician-owned companies and the commercial insurance industry. And in doing so, I mean no criticism of the commercial insurance industry, but I think it is important to your view of this situation that you recognize those differences.

Our companies are not in business to make a profit. Our companies use all investment income on premiums to keep rates down. So we take every penny of investment income and say we will reduce rates by reason of that income. We have historically extraordinarily low administrative costs. Many of us pay no broker's or acquisition fees. And we are, therefore, able to provide insurance coverage at the lowest possible rate consistent with insurance company solvency.

One added incentive. The doctors who run our company, who project what those rates shall be, are by and large practicing physicians. And when they vote on a rate increase, they know that eventually they are going to pay that very bill themselves. So they have the greatest possible incentive to keep rates down.

On the question of are our rates credible, I think it is clear that our rates are as credible as they can possibly be. But costs are only one part of the equation. Our tort system—and I have watched it over 35 years of professional life—is much too costly, far too time-consuming, and is not really equitable.

Please understand that the average case in many of our urban centers is not paid for anywhere from 6 to 10 years. And after all that period of time, with the anxiety and the frustration that litigants endure—and I mean all litigants, claimants and doctors and hospital personnel, we find that we spend more money to pay lawyers on both sides than we do to pay claimants.

Now, this may be heresy for a lawyer to say, but I say it. It is an intolerable situation when we pay more to support the cost of litigation than we do to those who come seeking redress. That cannot be in the public's best interest, and it is an enormous waste of our resources.

As physician-owned companies, we have an absolute obligation, and we don't think this is a "bad doctor" problem, but we have an absolute obligation to carefully monitor the practice of physicians we insure And we are faithful to that obligation. And doctors whose claim experience is generated by practice which falls below acceptable standards find through peer review that they don't have coverage, that they don't have coverage in areas where they are not competent, that they are required to pursue continuing medical education programs, that they are required to submit to office screening and audit procedures. And we have merit rating with most of our companies charging doctors whose claim experience is greater than average a higher rate than most doctors pay.

Further, we pursue all opportunities to both enhance patient safety and reduce medical injury. Our companies individually and our association have actively attempted to define those areas of claims and the kinds of medical injury which produce them, and go to our doctors and tell them what the problems are and do everything in our power to reduce those injuries.

We heard discussion earlier today about reforms. It seems to me that the reforms that have taken place that are most crucial in terms of their impact on States and premiums are those that in some way limit awards. A few States have accomplished those limitations; most have not. We seek your help in solving this crucial public problem. We need Federal legislation that would embody the kind of reforms enacted in California in 1975 to limit pain and suffering awards, provide collateral source offsets, and mandate structured settlements. Indeed, we welcome Mrs. Johnson's innovative proposal relating to Medicare beneficiaries.

Thank you very much. I will be delighted to answer any questions.

[The statement and attachment of Mr. Fager follow:]

STATEMENT OF DONALD J. FAGER, PHYSICIAN INSURERS ASSOCIATION OF AMERICA

My name is Donald J. Fager and I am here in behalf of the Physician Insurers Association of America (PIAA). I am a Past President and a member of the Board of Trustees Emeritus as well as the Chairman of the Legislative Committee of that Association. I am also Vice President of Medical Liability Mutual Insurance Company of New York, the largest physician owned insurance company in the country. Prior to becoming Vice President of Medical Liability Mutual in 1975, I was for almost 20 years, a trial lawyer defending physicians and hospitals in medical liability cases.

The PIAA is an organization of 42 companies insuring 177,000 physicians in this country. This number represents well over fifty percent of the doctors in private practice who purchase medical liability insurance. All of these companies are owned by physicians, and most of them were founded by their state medical societies. Our companies are in 40 states and the District of Columbia.

We are most grateful for your invitation to testify today on a matter of vital importance to our health care system and of concern for all Americans - the medical liability crisis. The crisis is of a different nature than it was fifteen years ago when the availability of medical liability insurance was very much in doubt. Today, it is a crisis of burdensome premium costs for physicians and hospitals which are ultimately borne by the general public. It is a crisis of access to care, particularly for the poor and in areas which are already medically underserved. It is a crisis of a tort liability system gone seriously awry with compensation for true victims of malpractice increasingly delayed while groundless claims frequently bedevil the practitioner and jury awards too often reach million and multi-million dollar levels[1].

Most of the PIAA companies were formed in 1975 and 1976 as a response to the "availability" crisis. The traditional insurers of this risk had, with few exceptions abandoned the business and with good reason. It was certainly not profitable and was fraught with extraordinary volatility. Doctors faced the dire prospect of practicing without insurance protection, and patients injured by negligent acts would have little or no opportunity to recover compensation for those injuries. In response to this public need, doctors decided to provide their own insurance mechanisms and our companies were organized throughout the country. The doctors entered the insurance business with the recognition that insurance entities, no matter how well administered, would not solve the liability problem without significant changes in tort law, particularly changes which would place some limits on awards. Regrettably, despite heroic efforts, such changes have been accomplished only in very few states.

I think it is important to understand the distinctions between the physician owned companies and the commercial insurance industry, but in making these observations, I do not mean to imply any criticism of the commercial industry. Most PIAA companies are not in business to make a profit and they use investment income, derived basically from prudent and conservative investments, to reduce or discount premiums. For example, if an actuarial projection for a given year suggests that losses will eventually cost several hundred million dollars, we deduct from that cost the investment income that we expect to earn until the losses are paid. The policyholders then are

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[1] In New York State alone, there have been verdicts within the past year of twenty million dollars (two physicians and a hospital), eleven million dollars (two physicians), and six million and five million dollars (neurologic deficit cases against obstetricians).

charged the discounted amount. Further, most of our companies do not pay acquisition or brokers' fees and their administrative expenses are well below those generally accepted in the industry. In short, our companies can provide insurance coverage at the lowest possible cost consistent with solvency of the insurance enterprise. Please bear in mind too, that physicians, as company Board members, have the greatest incentive to keep rates down: most are practicing physicians and have to pay those premiums. Accordingly, insurance regulators and government officials have attached great credibility to our rate projections.

Rates in my states have risen to dramatic and even obscene levels fueled by an enormously expensive and inequitable tort system. It is difficult to accept that a physician, regardless of income, should have to pay $100,000 in a single year to protect himself from professional liability claims and yet rates for the highest risk specialties are as much as $185,000 in Florida, $125,000 in New York, and $106,000 in Michigan; equivalent premiums in Maryland are $82,000, in Georgia, $76,000, in Illinois, $75,000, in the District of Columbia, $52,000, and in Maine, $48,000.

Premium costs alone do not fully reflect the gross inequities in the present system of compensating medical liability claimants. The system does not serve the interests of doctors, their patients or the public. It is tremendously expensive, much too time consuming, and too often results in widely disparate awards. In New York for example, it takes on average almost 10 years to compensate claimants, and during the intolerable delays patients and doctors suffer all of the anxieties and frustration of the litigation process. Moreover, we find that more than half of the total dollars spent do not go to patients at all, but to the lawyers on both sides of the case. It is intolerable to spend more to support the costs of litigation than to compensate claimants. This cannot be in the public interest and is a dreadful waste of our limited resources.

Some would like to create the fiction that the medical malpractice problem is a "bad doctor" problem. If that were true, it would mean that neurosurgeons and obstetricians are all bad doctors because their claim experience is the poorest and they pay the highest rates. The truth, of course, is that although highly trained and skillful, they practice in high risk specialties which leave them particularly open to large claims.[2] The situation in obstetrics is of particular concern. Data of the Physician Insurers Association reveals that claims involving infants with cerebral palsy are by far the most costly with average payments in excess of one half million dollars. (While most of the claims are brought against obstetricians, family practitioners, pediatricians and anesthesiologists are frequently involved). All of the glaring weaknesses of the medical liability compensation system are revealed in these cases. An infant with serious neurologic deficit (dramatized in court by "a day in the life" movies) has an entirely understandable emotional appeal to a jury. And yet, scientific evidence from studies of the National Institutes of Health tells us that the condition of most children with cerebral palsy is genetic in origin and has nothing to do with physician conduct.

The potential for awards in such cases is enormous and it is distressing, though not surprising, that lawyers specifically advertise for them. The impact of these claims on the practice

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[2] The Special Advisory Panel on medical malpractice in the State of New York, appointed by Governor Hugh Carey in 1976, reported that "the number of malpractice claims against physicians and hospitals continues to rise without any necessary relationship to negligent medical care and out best hospitals and specialists are frequently sued."

of obstetrics has been described at some length by the American College of Obstetrics and Gynecology. We are told that access to obstetrical care is of real concern in many areas of the country and the real tragedy of the liability situation is that the poor and those already without adequate medical care bear the greatest burden. Virginia and Florida have attempted by statute to remove these claims from the present system and provide compensation for medical and other expenses, but not pain and suffering, on a no fault basis.

The PIAA companies share a basic philosophy with regard to claims handling: those who have legitimate claims should be compensated as rapidly and equitably as possible; those who assert groundless claims should not be compensated at all and their claims vigorously resisted. Unfortunately, it has become increasingly difficult to settle legitimate claims early because publicity about large verdicts has whetted the appetite of claimants and their attorneys for greater and greater awards. While we have been reasonably successful in resolving cases without merit -- 60% or more claims are closed without payment -- the defense of such cases is costly, to say nothing of the time and effort which must be expended by the physician, and in many cases, several physicians.

Doctor insurers fully realize their obligation to improve quality care and enhance patient safety. Companies carefully review the claim experience of their policyholders in an effort to identify those doctors whose methods of practice fall below accepted standards of care. Careful peer review of claims enables companies to identify problem physicians at an early date and take appropriate action. That action may involve the following: cancellation or non-renewal of insurance coverage; restriction of coverage to areas of demonstrated competence with denial of coverage in other areas; requirement that doctors participate in continuing medical education programs; and screening or audit of doctors' offices. Most companies also have merit rating programs of one kind or another which permit them to charge higher premiums than usual for doctors with adverse claims experience.

The effectiveness of these procedures has been described in a recent study as follows: "PIAA companies are effective agents in detecting negligence-prone behavior. Surcharges and restrictions on practice put physicians on notice that the company is dissatisfied with their performance. Most important, the threat of termination of coverage and the problems that will then ensue are likely to provide a powerful stimulus to improved performance."[3]

PIAA companies are intensively involved in efforts to enhance patient safety. All companies have their own effective programs of risk management/loss prevention in which they seek to identify principal areas of medical injury and make recommendations to their insureds. Their findings are widely reported through meetings, seminars, video presentations, brochures and newsletters in an effort to reduce such injuries. In addition, the Association has its own programs and has been for several years collecting data from member companies on the types and costs of claims. A few years ago, the Association made a study of infant cerebral palsy claims and reported to the membership on its findings. There is an ongoing study of claims involving alleged failure to diagnose cancer of the breast and other studies will be undertaken as conditions warrant. There is some feeling that the recent moderation in the frequency of

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[3]"The role of Physician-Owned Insurance Companies in the Detection and Deterrence of Negligence" by William B. Schwartz, M.D., Daniel Mendelson - Please see appendix.

claims may be due, in part, to the efforts of our companies in the risk management area.

We feel strongly that patients who are injured as the result of malpractice are entitled to prompt and equitable compensation. Regrettably, the present system is a total failure in this regard. As has been stated before, the compensation system is extremely protracted and very costly with results that can hardly be called equitable. The costs involved have serious implications for the health care system in our country.

A few states have enacted legislation which has helped to control the rising tide of malpractice awards. However, in most states, efforts to accomplish significant reform have been thoroughly frustrated. We think it is time for a federal role in this vitally important process. We urge you to enact federal preemptive legislation containing the type of reforms enacted in California in 1975[4] which would place a $250,000 cap on non-economic awards and provide for periodic payment of future damage awards, mandatory offsets of collateral sources, and restriction of attorney's contingency fees. In this regard, we note that H.R. 4566, which has been introduced by Rep. Nancy Johnson, is an important step in the right direction. The reforms adopted in California have kept that state's highest rates at a level about fifty percent lower than the rates in states such as New York, Florida, and Michigan.

In discussing the financial aspects of this issue, we often lose sight of the human elements. The relationship of doctor and patient has suffered incalculable harm. Too often doctor and patient are suspicious of each other. We must diminish the threat of liability and restore that relationship to one of mutual trust and confidence.

We have cooperated fully with the General Accounting Office and other federal agencies that have studied this issue. We pledge to continue to provide any assistance you need in attempting to solve this crucial public problem.

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[4]Please see a report on the California reforms by PIAA President Brad Cohen, M.D. in the appendix.

The Role of Physician-Owned Insurance Companies in the Detection and Deterrence of Negligence

William B. Schwartz, MD; Daniel N. Mendelson

This study presents evidence that physician-owned insurance companies and their physician members play an important role in the detection and deterrence of negligent behavior. A survey of physician-owned companies indicates that 94% involve their physicians in one or more aspects of the underwriting process. About 60% involve their members in assessing the competence of physicians who have been sued and in advising the underwriters on decisions concerning both continued insurability and the conditions of insurance. During 1985, a total of 0.66% of the physicians in physician-owned companies had their insurance terminated or were forced to give up their coverage because of negligence-prone behavior. An additional 0.7% of active policyholders were subject to restrictions on practice or other medical sanctions and 1.8% to surcharges and deductibles. Thus, disciplinary actions were in place against 3.2% of insured physicians whose performance was viewed as in some way substandard. The findings indicate that the physician-owned companies are effective agents in identifying negligence-prone behavior, and suggest that these companies also play an important role in deterring substandard performance.

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THE DETECTION and deterrence of medical negligence is now a major public issue. Federal legislation that will make information on negligent behavior available to credentialing boards and hospitals is now in place,[1] and state boards and hospitals are under increasing pressure to play a more assertive disciplinary role.

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The opinions and conclusions expressed herein are solely those of the authors and should not be construed as representing the opinions or policies of The Robert Wood Johnson Foundation, Princeton, NJ, the Department of Health and Human Services, Washington, DC, or The RAND Corporation, Santa Monica, Calif.

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The present study focuses on the physician-owned insurance industry, which currently insures about 40% of physicians in patient care. Physician-owned companies are unique in that the physicians they insure have a powerful financial incentive to help detect and discipline negligence-prone colleagues.

See also pp 1335 and 1378.

Moreover, physicians who assist in this process have peer approval because the companies are typically sponsored by the county or state medical society.

This study is based on a survey of the 40 physician-owned insurance companies that were members of the Physician Insurers Association of America (PIAA) as of 1985. Eighty-five percent of the PIAA companies (which insured 85% of PIAA physicians in 1986) responded to the survey (Table 1). Three of the companies were not members of PIAA during the entire 3-year study period and were, therefore, excluded from the analysis.

The first section of this study analyzes the use of peer review in decisions on who is to be insured and under what conditions, using both survey data and in-depth case studies of four companies. The second section employs data from the survey to determine the fraction of physicians in the PIAA pool who were disciplined for negligence and the frequency with which various medical and fiscal sanctions were imposed. Finally, the disciplinary role of PIAA companies is compared with that of state medical boards and hospital peer-review committees.

THE ROLE OF PHYSICIANS IN THE UNDERWRITING PROCESS

Ninety-four percent of the companies involved physician members in some aspect of the underwriting process. In 60% of the companies, physicians were instrumental in reviewing the competence of those who had been sued and making recommendations to the underwriters on what actions should be taken. About 30% indicated that new applicants are routinely reviewed by a committee composed of physicians.

To obtain deeper insight into the peer-review process, the operations of

Table 1.—Extent of Survey Coverage

	Coverage of PIAA Physicians and Companies		
	1984	1985	1986
Total PIAA membership	136 170	135 913	143 970
No. of physicians in valid survey responses	116 547	116 082	122 198
% of total members in the analysis	86	85	85
Coverage Relative to Overall Pool of Insured Physicians			
Estimated No. of insured allopathic physicians in U.S.*	390 000		
% of insured allopathic physicians in PIAA companies (as of 1986)	37		
% of insured allopathic physicians covered by this survey (as of 1986)	31		

*We estimated this figure by assuming that all patient-care physicians and teaching physicians carried insurance, and that 25% of non–patient-care physicians carried insurance. Patient-care physicians are those who spend more than 50% of their time in practice. (Source: *Physician Characteristics and Distribution in the U.S.* 1988. Chicago, Ill: American Medical Association; 1988.) These figures do not include resident physicians.

four companies were studied in detail. The descriptions of these companies are based on extensive interviews with underwriters from each company, attendance at one or two committee meetings in each of the three companies that have such meetings, and discussions with members of the peer-review committees. This article will describe in greatest detail a company that has a peer-review committee whose sole function is to assess physician performance and to provide advice to the underwriters. This company was chosen for detailed observation because it is viewed as having one of the most effective underwriting programs and because of the insight it provides into the dynamics of peer review.

Company I

Triggers That Lead to Review.—The peer-review process is typically set into motion by a single claim that, when examined by the underwriter, raises questions about the standard of care. A case is not brought before a committee until the claim that triggered the review has been closed because the company is concerned that a breach of confidence could allow the committee's appraisal to reach the plaintiff's counsel. An exception is made if a physician's performance is judged to be so poor that immediate action is considered necessary. The committee is not told by the underwriters about the disposition of the case, whether it was settled out of court, went to trial, or whether any payment was made. A review can also be triggered when a physician is disciplined by a hospital or by the state medical board or if there is other evidence suggesting that performance has been substandard.

The Composition of the Committee.—Each county has a committee consisting of 10 to 25 volunteers chosen for their clinical competence. To minimize the potential for anticompetitive behavior, the selection process is designed to provide a wide representation of specialties and hospitals within the county. Underwriters are present at committee meetings but lawyers are not. Committee members indicate that a variety of reasons lead them to volunteer for membership, including the desire to learn more medicine, a break from routine, prestige, and the fascination of dealing with difficult and controversial medical issues. The negative aspect is that committee members are resented by some of their colleagues because of the judgmental role they play. If there is any reason to believe that an objective review is not possible, the case is referred to the committee of another county.

How the Committee Functions.—Each committee typically meets monthly and reviews three cases during a 2- to 3-hour period. Between 1979 and 1987 they reviewed 976 physicians. In 1987, a total of 102 were reviewed and sanctions were imposed on 77, or about three fourths.

The claim that triggered the review is presented and analyzed by a physician from the same discipline as the physician being assessed. The committee then evaluates the specific case under consideration and a vote is taken on whether the physician performed at an acceptable level. To assess the physician's overall competence, the committee then reviews previous claims and votes on five "risk characteristics"—medical judgment, rapport with patients, general health, general practice characteristics (practice in areas beyond training or competence), and overall professional conduct. The committee members then vote on whether, from the point of view of continuing insurance coverage, the physician presents (1) an acceptable risk, (2) a questionable risk, or (3) an unacceptable risk. A physician may be considered an acceptable risk even if the committee found negligence in the case at hand. The results of the committee's votes and their recommendations are then submitted to the underwriters.

The Underwriters' Role and the Interaction Between Peer-Review Committees and Underwriters.—The underwriters make the final recommendation regarding insurability to the board of the company and take the responsibility for difficult decisions. Although the underwriters depend heavily on the views of the committee, they are not bound by these views. The underwriters feel that the committee system provides a unique forum for an overall assessment of the physician's competence, and their recommendation to the board concerning whether to terminate or continue an insured physician's coverage usually coincides with the committee's recommendation. Although the underwriters use consultants from outside the company to evaluate claims, they have the concern that an individual consultant may be biased or mistaken.

Recommendations on surcharges are made solely by the underwriters, although the committees' comments are an important factor in shaping their decisions. On the other hand, the underwriters usually rely on the committee's recommendations concerning medical sanctions such as restrictions on practice.

Information on Practice Patterns and Personal Characteristics.—Physician members may also make inquiries of the physician's colleagues, hospital administrators, the local medical society, and specialty societies to identify additional issues that require further exploration and possible documentation. For example, if there are reports that the physician does not use consultants where expert advice is clearly required, his claims files will be reviewed to determine if the criticism is valid. If reports indicate that the physician is carrying an excessive work load, appropriate inquiries will be made. According to the underwriters, unconfirmed allegations are not used in decision making.

Companies II, III, and IV

Although companies II, III, and IV have many features in common with company I, the peer-review committees are structured differently. The underwriters of company II draw primarily on the deliberations of a claims review committee whose function is solely to assist in the defense of the case by determining whether the physician was

negligent. Overall evaluation of the insured is not the purpose of the group, but the underwriters are present at the meeting and the discussion of the physician's performance provides them with important insights.

Company III employs two kinds of peer review. The first typically involves detailed review of a claim by one or two physicians who are considered highly qualified in the particular specialty. Their primary responsibility is to determine whether the physician met an acceptable standard of practice, but they also work with the claims department and the company's lawyer to decide whether the case is legally defensible. A second peer-review committee, consisting of 8 or 10 physicians, reviews physicians who have been identified by a penalty-point system as being of questionable competence (points are assessed against physicians with claims against them on the basis of such factors as severity of the injury and the likelihood that the physician was negligent). A physician is reviewed when he exceeds a predetermined point threshold. The committee then decides whether the point score should be adjusted upward or downward. For example, if the findings suggest that the case is one of "aggravated negligence" (grossly poor performance), the point score is increased. On the other hand, the score may be lowered if the negligent injury is minor, such as a chipped tooth. If, after the review, the score still exceeds a particular threshold, a surcharge or some other sanction is assessed against the physician. If the committee is particularly concerned about a physician's competence, it assesses the physician's overall performance to determine whether to recommend that insurance coverage be terminated.

Companies II and III also make use of other strategies described in connection with company I. For example, a review can be triggered not only by a claim but also by action of the state board or on the basis of information brought to the underwriters' attention by other members of the company. These companies also may make inquiries to colleagues, administrators, and various medical societies about the professional competence and practice patterns of the physician being reviewed. They may also ask a physician of dubious competence to attend a meeting where further quality assessment can be carried out.

Company IV uses its peer-review committees in an ad hoc advisory role. A three-member committee in each specialty is available to the underwriters for consultation.

Each of the four companies has elaborate mechanisms for appeal culminating in an appeal to the board of the company; such boards are composed entirely of physician members.

Summary of Peer-Review Observations

Both the survey and case studies indicate that physicians in most PIAA companies play an active role in assessing physician performance and in providing advice on applications, termination of insurance, surcharges, and other disciplinary actions. A wide range of strategies is used to achieve these goals, but the most impressive example is seen in the case of company I, which has a peer-review committee devoted solely to assessing physician competence. Their review is typically triggered by a claim suggestive of negligent behavior; after reviewing this claim, the committee examines earlier claims to assess the physician's professional competence. Members of the committee also assist the underwriters by acquiring other information on work load, willingness to seek consultations, and other matters that may merit further exploration. Other companies use a peer-review committee in an advisory role and some rely on individual physicians' expert advice. Such in-depth analysis by peers allows a PIAA insurer to better determine the action appropriate for dealing with each problematic situation. Finally, the peer-review process also allows the company to circumvent the delays and difficulties inherent in reliance on actuarial claims experience to detect that a physician is negligence prone. Typically, 5 or more years may be required before actuarial data on claims frequency and payments allow a company to determine whether a physician poses an unduly high risk. Moreover, such assessments are almost certainly less accurate than those made on the basis of a review of competence.

SANCTIONS AGAINST NEGLIGENCE-PRONE PHYSICIANS

Data from the survey of PIAA companies have indicated that in 1985, a total of 0.96% of physicians had their insurance terminated or were forced to give up their coverage because of negligence-prone behavior (0.49% and 0.17%, respectively) (Table 2). An additional 1.6% of physicians were subjected to surcharges and 0.9% to other sanctions, financial or medical (Table 3).

Alerted to the fact that their insurance may be terminated, physicians often prefer to resign so that they can seek other insurance without the stigma of cancellation. The company also prefers resignation over termination because the possibility of suit or intervention by the state insurance commissioner is reduced: if insurance is formally terminated, the physician is more likely to accuse the company of acting in bad faith, collusion, or failure to follow due process.

Table 2.—Loss of Insurance due to Negligence-Prone Behavior by PIAA Insured Physicians*

	% of Physicians		
	1983	1984	1985
Insured terminated	29	34	49
Resigned under pressure	13	16	17
Total	42	50	66

*This analysis considers only the 31 companies that were members of Physician Insurers Association of America (PIAA) during the entire study period and that responded to the survey. The fraction of companies that did not terminate the insurance of any physicians ranged from 10% to 18% over the 3 years of the study. The fraction of companies not responding to the question ranged from 3% to 10% over the 3 years. The fraction of companies that did not force any physicians to resign was 22% in each year; the fraction of companies not responding to the question ranged from 33% to 42% over the 3 years.

Fiscal Sanctions

The survey data indicate that 90% of the companies used surcharges as a fiscal penalty and 13% used deductibles; only one company used coinsurance (Table 3). Surcharges are popular because they are easy to impose and because payments can be assessed as part of the premium. The four case studies reveal that the types of surcharges and the mechanisms that activate them can vary widely. Company I surcharges a physician 10% of the premium if a claim is adjudged to be the result of negligence; if a second such claim occurs, the surcharge is raised to 20%. Company IV uses surcharges of 50% to 100% depending on the perceived extra risk posed by the physician; company II uses surcharges of 50% to 200%. Company III usually imposes surcharges ranging from $3000 to $5000 per year. Surcharges are typically in effect for a period ranging from 1 to 3 years.

According to underwriters, deductibles are rarely used because they give the physician an incentive not to report an incident promptly. The physician's hope is that a claim will not be filed and that he can thus avoid paying the expenses involved when the company opens a file and investigates a report. But if the physician fails to file a report it may lead to serious problems for the insurer; if an action against the physician is ultimately filed, the delay adds to the difficulty of investigating and defending the case. Physicians facing a deductible also tend to create problems for the company by interfering in the way that the case is handled by the

Table 3.—Number of Disciplinary Actions Among Policyholders in 1985*

	Medical Sanctions		
	Restrictions on Practice, %	Further Training, %	Supervision, %
% of companies employing sanction	87.1	41.9	35.5
In companies that use sanction, % of physicians affected	0.9	0.1	0.2
% of sample physicians affected	0.5	0.1	0.1

	Fiscal Sanctions		
	Surcharges, %	Deductibles, %	Coinsurance, %
% of companies employing sanction	90.3	†2.9	3.2
In companies that use sanction, % of physicians affected	2.2	1.1	0.0†
% of sample physicians affected	1.8	0.2	0.0

*This analysis considers only the 31 companies that were members of the PIAA during the entire study period and that responded to the survey. The number of missing values varied from question to question, but never exceeded 10% of the sample.

†One company used coinsurance, but did not specify how many physicians were affected.

claims staff. Any expenditure by the insurer that falls within the limits of the deductible often leads to a complaint from the physician that the company is spending too much of "his money." Companies also object to deductibles because they often have difficulty in collecting the funds due them.

Coinsurance provisions are used infrequently because they create difficulties between the insurer and the physician on both the question of settlement and of going to trial.

Medical Sanctions

If a physician's performance is unsatisfactory but not so bad as to warrant termination of coverage, medical sanctions such as restrictions on practice are sometimes imposed. The survey shows that nearly all companies make use of some type of sanction; a total of about 0.7% of the insured were subject to medical sanctions as of 1985 (Table 3). The great majority of such actions consisted of restrictions on practice. According to underwriters, this is because such restrictions are relatively easy to enforce. Supervision of certain of the physician's activities by a consultant is not often used because it is time consuming and difficult to employ. In some instances, the physician is required to take a period of further training; however, this requirement is uncommonly imposed because of the hardship that it exacts on the physician—typically many months away from practice and often away from home.

Possible Effects of Sanctions on Physician Behavior

Medical and Fiscal Sanctions.—In the absence of data, it is difficult to be certain of the effect that sanctions have on quality of care; it seems likely, however, that each would have a beneficial effect. If a physician is barred from carrying out a procedure he is not competent to perform, or if he is required to operate under the guidance of a more skillful physician, the frequency of negligent behavior should be reduced. Further formal training designed to improve skills should also enhance performance, as should supervision by a competent colleague.

It is not clear whether surcharges of the size employed by the PIAA companies have an appreciable influence on behavior. Many underwriters do not believe that a surcharge of several thousand dollars (or even $5000 or $10 000) has a notable deterrent effect. Instead, they impose such penalties simply to warn the physician that more severe sanctions are likely if performance does not improve. Surcharges amounting to 50% or 100% of the premium presumably give the physician a far more powerful incentive to improve, but studies on the effectiveness of such penalties have not been done.

Termination of Coverage.—The PIAA companies are able to identify and expel individuals who presumably pose the most severe risks to quality of care; such actions themselves do not ensure quality of care, but the threat of termination of insurance almost certainly acts as a significant deterrent to substandard performance.

Physicians who lose standard-lines coverage have many options, however. They can continue in practice without penalty by obtaining coverage from a joint underwriting association, entering a military service, or joining the staff of a Veterans Administration or a state or municipal hospital. In many states they can obtain insurance through a surplus-lines company that accepts virtually any physician, albeit at a penalty consisting of a premium several times higher than normal, a substantial deductible, and often restrictions on the characteristics of their practice.[7] Physicians who lose their insurance can also, at some personal risk, decide to practice without insurance.

PIAA COMPANIES COMPARED WITH STATE BOARDS

State boards in 1985 revoked or suspended the licenses of 0.16% of the 390 000 estimated insured physicians in patient care and took less severe actions such as reprimands, admonishments, limitations on narcotics permits, and restrictions on practice in another 0.38%.[8] According to the Office of the Inspector General, about half of the actions by the board were based on inappropriate writing of prescriptions and another quarter on self-abuse of drugs or alcohol. Among the remaining cases, the most common causes were convictions for felony or fraud. Strikingly few actions were imposed on the basis of medical incompetence or malpractice.[9]

Even if some substantial fraction of the instances of substance abuse involved some element of negligent performance, it is highly unlikely that more than half of the board's actions were related to incompetence. Taking this value as an extreme upper bound, it appears that no more than 0.08% of US physicians lost their right to practice (license suspension or revocation) because of negligent behavior. By contrast, nearly 0.66% of PIAA physicians were viewed as sufficiently negligence prone to warrant termination of their insurance coverage.

If half of the lesser penalties imposed by the boards were related to negligence, it would follow that no more than about 0.19% of US physicians were subjected to such minor sanctions. In 1985, PIAA companies had minor disciplinary actions (restrictions on practice and surcharges) in place against 2.5% of their members.

Any comparison of state boards with PIAA companies must take into account that license suspension or revocation is a far more serious action than any that an insurer can take. Thus, one might expect such serious board sanctions to be fewer in number than termination of coverage, the most draconian penalty that can be imposed by a PIAA company. But the overall rates at which PIAA companies discipline physicians for substandard performance is many times higher than that of state boards, so it appears that the boards still have much to accomplish.

That the boards have difficulties in identifying and dealing with substandard physicians is hardly surprising given the various impediments that they face. One important element is the requirement that there be "clear and convincing evidence" of negligence rather than simply a "preponderance of evidence." A second problem is that the boards lack the peer-review capabilities

available to the PIAA insurers; this shortcoming makes it far more difficult to adequately evaluate overall physician competence. Finally, the effectiveness of the boards is constrained by a lack of resources and a rapidly expanding work load.[6] Large backlogs, amounting to hundreds of cases, are not uncommon; individual investigators are often burdened with 70 or more cases. This difficult situation is being compounded by an increase in mandated reporting; recent federal legislation has established a national center to which all malpractice payments and disciplinary actions by hospitals and state boards must be reported.[1]

It is possible that sufficient additional resources will be funneled into the state boards' activities to improve the situation, but even with adequate resources there are significant impediments to effectively resolving cases that involve negligence. The complexity of internal review and time-consuming administrative procedures are obstacles to be overcome if the boards are to function more effectively.[6]

THE HOSPITAL PEER-REVIEW COMMITTEE

The hospital peer-review committee should have a considerable advantage over a PIAA company in evaluating physician competence and imposing appropriate sanctions because the physician being evaluated is typically well known to the members of the group. But the problem of obtaining an objective appraisal and taking appropriate actions is far more difficult in hospitals than in a physician-owned insurance company. Hospital committee members are likely to be reluctant to move against a colleague with whom they work regularly and whom they see socially. The committees of PIAA companies face few problems in this regard because they are usually composed of physicians from many hospitals.

Peer-review committees are now confronted with the new problem posed by the recent Supreme Court decision in *Patrick v Burget* (*New York Times*, May 17, 1988:A1).[8] In this case, the court ruled that physician members of a peer-review committee can be sued under federal antitrust law. The Supreme Court stated that "to the extent that Congress has declined to exempt peer review from the reach of antitrust laws [under the Health Care Quality Improvement Act of 1986], peer review is immune from antitrust scrutiny only if the state has made this conduct its own." According to the American Medical Association, a committee can be protected from such actions if state laws are amended to ensure sufficient formal review within the state system (*New York Times*, May 17, 1988:A1). But concern over this new development can only further discourage effective hospital peer review, at least in the short run.

Whether antitrust concerns will appreciably affect peer-review committees in PIAA insurance companies is uncertain. Because these committees typically are made up of representatives from a large number of hospitals, there seems to be less likelihood of charges alleging anticompetitive action.

To summarize, the data suggest that the PIAA companies are effective agents in detecting negligence-prone behavior and also play an important role in deterring substandard behavior. Surcharges and restrictions on practice put physicians on notice that the company is dissatisfied with their performance. Most important, the threat of termination of coverage and the problems that will then ensue are likely to provide a powerful stimulus to improved performance.

This study was supported in part by a grant from The Robert Wood Johnson Foundation, Princeton, NJ, and the Department of Health and Human Services grant #6ASPE172A, Washington, DC.

We wish to express our appreciation to Peter Sweetland and William A. Reilly of the Medical Inter-Insurance Exchange of New Jersey, Lawrenceville, for circulating the survey instrument and to Bernice M. Golder for her valuable assistance in the preparation of the manuscript.

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Mr. COYNE. Thank you. I would like to thank you for your testimony and I yield to Mr. Pickle for his questions.

Mr. PICKLE. Well, I thank you, Mr. Chairman and appreciate your courtesy. I think, first, I would want to say to the gentleman who just testified with respect to the AARP, I ask you does AARP pay any tax on revenue from their group health insurance program?

Mr. AMSDEN. I do not personally know.

Mr. PICKLE. Did someone from the AARP testify?

Mr. AMSDEN. I am the AARP representative and I will have to defer to the staff and see that you get an answer to that in writing. I, personally, do not know the answer to your question, but I will see that you get that answer.

Mr. PICKLE. Well, let me help you there.

We had a hearing before our Oversight Subcommittee on this question of unrelated business income tax approximately 1 or 2 years ago now. You said that in 1978, your program was audited with respect to revenue from the group health insurance, and that the Internal Revenue Service ruled that it was substantially related and therefore, you pay no tax on your group health insurance program at 1978.

And if you do not know anything about the subject, you would not know whether that has changed any or not, would you?

Mr. AMSDEN. Correct, I would not know.

Mr. PICKLE. You would not. You said, at that time, that that program was the second largest source of income of your whole AARP operation. I do not know whether it is now or not, I just do not know that, but I have to assume that it probably is and that it is still the second largest source of income for AARP and you pay no unrelated business income tax, if the IRS still has that ruling.

Is that correct, do you know?

Mr. AMSDEN. I am not familiar with the insurance.

Mr. PICKLE. If that is so, then it raises a question to me. All organizations across this land who have a similar type of income-related program, probably pay no tax, and I have to ask myself, where do you draw the line?

Now, that is a subject that we have gone into and not a subject of this hearing. But I just want to point it out.

Now, also what I would say to all of this panel, that I have found the comments very interesting. You have all taken different, almost diametrically opposite positions.

I want to commend you, Doctor Todd, for the AMA's position, that you said that this is a national problem and it will take Federal intervention and so far as I know, that is the first time the AMA has ever recommended any kind of action by the Federal Government. I want it to go down into the record, that that is important.

[The following was subsequently received:]

AARP

May 25, 1990

The Honorable J.J. Pickle
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Pickle:

This letter is in response to the questions you raised at the Ways and Means Subcommittee hearing on April 26, 1990, regarding the tax treatment of income AARP receives from its group health insurance program.

The information we have been asked to provide and which is contained in this letter is similar to that provided to you on other occasions including in an October 4, 1988 letter responding to questions you raised during a Ways and Means Oversight Subcommittee Hearing; and in testimony before the Subcommittee on June 29, 1987. As with our prior responses, we request that this letter and the attachment be inserted in the appropriate place in the Ways and Means Health Subcommittee's hearing record.

The availability of proper health care has always been an especially critical concern of AARP and older Americans. To meet this concern AARP established its group health insurance program in the 1950's.

AARP pioneered the concept of group health insurance designed for older Americans. At the time the program was instituted, there was no such insurance generally available. Insurance companies were reluctant to enter this field because of the exposure to major risks and the lack of any precedent proving the viability of such insurance on a major scale. Dr. Ethel Percy Andrus, AARP's founder, was able to get a commercial insurer to take these risks and offer such coverage, with no health questions, modest pre-existing condition limitations, and reasonable identical rates for all members, whatever their age and wherever they resided.

It was found that such insurance satisfied an important need of the elderly and since that time, AARP has continuously arranged for group medical insurance plans for its members. The group health insurance program is presently used by 6.8 million AARP members and its availability to AARP's members has been a singularly unique hallmark of AARP's programs in fulfilling AARP's purposes of "enhancing the quality of life for older persons" and aiding the elderly in their needs -- especially their physical and economic needs.

AARP, through a trust established for this purpose, maintains the group health insurance program for its members by contracts with an unrelated commercial insurance company (currently, the Prudential Insurance Company of America). AARP selected the current insurance provider in 1981 with the assistance of the Towers, Perrin, Foster & Crosby consulting firm, which invited 64 companies to participate and reviewed proposals from 16 of those companies. AARP has a contract with Prudential establishing standards for availability, premiums, loss ratios, claims services, and the insurance company's profit (which in no event can exceed 1.75 percent of earned premiums). Because complete health coverage for the elderly has yet to be offered at any level of government, this program remains critical to the elderly and the purposes of AARP.

AARP's group health insurance program directly promotes the social welfare of older Americans. AARP receives an administrative allowance, currently at approximately 3.3% of the premiums under the program which is reported to AARP's entire membership in its annual report, and to the Internal Revenue Service on AARP's annual Form 990, as income substantially related to AARP's social welfare purposes.

In response to your question about the relative size of sources of support to AARP, the statement presented to the subcommittee by Cyril F. Brickfield on behalf of AARP in June, 1987 continues to be accurate. Aside from government and other grant funds dedicated to specific uses, these sources of support are, in order of magnitude, membership dues, administrative allowances derived in connection with the group health insurance program, investment income (which includes royalty income and interest income, some of which is derived from the investment of funds related to the group health insurance program) and advertising.

For your further understanding of AARP's sources of support, I have attached a copy of our 1988 financial statement, which was published in the AARP Bulletin and thereby made available to all members. The 1989 statement will be published in the July Bulletin and will be made available to you in the near future.

AARP members might very well be better off if we had a national health program. They certainly would benefit from more extensive and comprehensive Medicare coverage. These are areas in which AARP's legislative advocacy efforts continue, as you well know, despite the fact that if Medicare were so expanded, our members may not need supplemental health insurance. AARP has always been, and will remain, committed to such efforts.

If I can be of further assistance in this matter, please do not hesitate to contact me.

Sincerely,

Horace B. Deets

cc: The Honorable Fortney Stark

AMERICAN ASSOCIATION OF RETIRED PERSONS

CONSOLIDATED BALANCE SHEET

	December 31 1988	1987
ASSETS		
Cash	$ 1,232,000	$ 4,733,000
Treasury bills	101,092,000	65,458,000
Short-term investments committed to unearned membership dues	101,767,000	87,154,000
Accounts receivable	22,109,000	16,496,000
Prepaid expenses	7,507,000	10,115,000
Notes receivable	944,000	1,496,000
Property, furniture and equipment (net)	13,483,000	13,483,000
Total assets before government grant assets and liabilities	248,134,000	198,935,000
Cash restricted and accounts receivable for government grant commitments	3,078,000	2,531,000
Government grant commitments	(3,078,000)	(2,531,000)
Total assets	$248,134,000	$198,935,000
LIABILITIES AND FUND BALANCES		
Liabilities		
Unearned membership dues	$101,767,000	$ 87,154,000
Accounts payable	22,005,000	21,639,000
Accrued expenses	2,822,000	4,660,000
Accrued post-retirement benefits	11,724,000	9,825,000
Total liabilities	138,318,000	123,278,000
Fund balances		
Designated by Board of Directors	24,350,000	17,500,000
Undesignated	85,466,000	58,157,000
Total fund balances	109,816,000	75,657,000
Total liabilities and fund balances	$248,134,000	$198,935,000

CONSOLIDATED STATEMENT OF REVENUES, EXPENSES AND CHANGES IN FUND BALANCES

	Year ended December 31 1988	1987
Operating revenues		
Membership dues	$ 89,800,000	$ 81,347,000
Group insurance administrative allowances	74,057,000	67,191,000
Publication advertising	33,530,000	34,110,000
Income from other programs and royalties	30,154,000	30,951,000
Interest income	31,409,000	23,257,000
Other income	3,070,000	244,000
Total operating revenues	262,020,000	237,100,000
Operating expenses		
Publications	81,008,000	70,438,000
Programs and field services	45,573,000	41,490,000
Legislation, research and development	10,237,000	9,799,000
Member services and acquisition	58,951,000	55,602,000
Activities and facilities administration	19,116,000	16,564,000
Headquarters operation	12,976,000	10,802,000
Total operating expenses	227,861,000	204,695,000
Excess of operating revenues over operating expenses	34,159,000	32,405,000
Government grant revenues	62,547,000	55,172,000
Government grant expenses	(62,547,000)	(55,172,000)
Excess of revenues over expenses	34,159,000	32,405,000
Amount designated by Board of Directors	(6,850,000)	(17,500,000)
Amount added to undesignated funds	27,309,000	14,905,000
Undesignated fund balance, beginning of year	58,157,000	43,252,000
Undesignated fund balance, end of year	$ 85,466,000	$ 58,157,000

CONSOLIDATED STATEMENT OF CASH FLOWS

	Year ended December 31 1988	1987
Cash flows from operating activities:		
Excess of revenues over expenses	$34,159,000	$32,405,000
Adjustments to reconcile excess of revenues over expenses to net cash provided by operating activities—		
Depreciation and amortization	3,830,000	3,286,000
Gain on sale of property	(2,553,000)	-
Increase in unearned membership dues	14,613,000	13,963,000
Changes in assets and liabilities—		
Increase in short-term investments committed to unearned membership dues	(14,613,000)	(13,963,000)
Increase in accounts receivable	(5,613,000)	(2,671,000)
Decrease/(increase) in prepaid expenses	2,608,000	(1,990,000)
Decrease in notes receivable	552,000	397,000
Increase in accounts payable	366,000	1,755,000
Increase/(decrease) in accrued expenses	(1,838,000)	1,411,000
Increase in accrued post-retirement benefits	1,899,000	6,825,000
Total adjustments	(749,000)	9,013,000
Net cash provided by operating activities	33,410,000	41,418,000
Cash flows from investing activities:		
Capital expenditures for—		
Property	(19,024,000)	-
Furniture and equipment	(5,253,000)	(2,988,000)
Proceeds from sale of property	23,000,000	-
Increase in treasury bills	(35,634,000)	(38,019,000)
Net cash used by investing activities	(36,911,000)	(41,007,000)
Net increase (decrease) in cash	(3,501,000)	411,000
Cash at beginning of year	4,733,000	4,322,000
Cash at end of year	$ 1,232,000	$ 4,733,000

REPORT OF INDEPENDENT ACCOUNTANTS

March 3, 1989

To the Board of Directors of
American Association of Retired Persons

In our opinion, the accompanying consolidated balance sheet and the related consolidated statements of revenues, expenses and changes in fund balances and of cash flows present fairly, in all material respects, the financial position of American Association of Retired Persons and its subsidiaries at December 31, 1988 and 1987, and the results of their operations and their cash flows for the years then ended in conformity with generally accepted accounting principles. These financial statements are the responsibility of the Association's management; our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits of these statements in accordance with generally accepted auditing standards which require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for the opinion expressed above.

Los Angeles, CA Price Waterhouse

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Description of Organization: The American Association of Retired Persons (AARP) was organized in 1958 as a nonprofit corporation for the purpose of promoting the interests of older persons. AARP has qualified as a tax-exempt organization under Section 501(c)(4) of the Internal Revenue Code. AARP-sponsored programs include educational, research and social welfare activities with regard to older persons. AARP also publishes bi-monthly magazines and monthly news bulletins which are distributed to its members.

Significant Accounting Policies: AARP prepares its consolidated financial statements on the accrual basis of accounting. The consolidated financial statements of AARP include the accounts of AARP Financial Services Corp., AARP Service Company and the AARP Administrative Fund but do not include the accounts of the approximately 3,600 chapters of AARP that are organized and operate as separate entities. All significant intercompany transactions have been eliminated.

As a result of the Financial Accounting Standards Board issuing Statement No. 95 "Statement of Cash Flows," AARP has changed the format of its consolidated statement of cash flows to comply with this pronouncement. Accordingly, amounts for the prior year have been restated to conform with the new format.

AARP and its members benefit from the efforts of many volunteers. Travel and subsistence costs incurred by numerous volunteers in carrying out their duties are reimbursed by AARP. It is not practical to quantify the value of these volunteer services and therefore, these in-kind contributions are not recorded in the financial statements.

Members are given the option of paying for one-year, three-year, ten-year or lifetime memberships. The portion of membership dues applicable to publications is deferred until the related cost is incurred for those members whose dues are paid in advance.

Property, furniture, leasehold improvements and equipment are stated at cost. Depreciation is provided using the straight-line method over the estimated useful lives of the assets which range from three to ten years. Maintenance and repair costs are expensed as incurred, while renewals and betterments are capitalized.

AARP summarizes the costs of providing its various programs and other activities on a functional basis in the statement of revenues, expenses and changes in fund balances. Accordingly, certain costs are allocated among the programs and supporting services which are benefited.

The resources of AARP are included in a single fund for accounting purposes. The fund consists of undesignated fund balances and fund balances designated by the Board of Directors. The undesignated fund consists of unrestricted amounts expendable for the annual maintenance, preservation and administration of the Association. Designated funds are amounts which may be expended only for programs or purposes designated by the Board of Directors.

AARP Financial Services Corp. and AARP Service Company: AARP Financial Services Corp. ("Financial Services") and Scudder Stevens and Clark are partners in AARP/Scudder Financial Management Company, the investment advisor to the AARP Investment Program from Scudder. AARP Service Company ("Service Company"), a wholly owned subsidiary of AARP Financial Services Corp., provides certain oversight and management services to AARP Federal Credit Union.

Property, Furniture and Equipment: Property, furniture and equipment comprises the following:

	December 31	
	1988	1987
Furniture and equipment	$16,945,000	$12,982,000
Leasehold improvements	1,988,000	3,777,000
Computer software	5,094,000	4,438,000
Less accumulated depreciation and amortization	(10,544,000)	(7,714,000)
Net property, furniture and equipment	$13,483,000	$13,483,000

Government Grants: AARP administers government grants. Under the major grant, which has as its purpose the placement of older persons in unsubsidized employment, approximately 8,500 persons are currently enrolled at 108 sites in 33 states and Puerto Rico. This grant has been renewed annually since 1969; the primary commitment expires in June 1989, and future funding through June 1990 is expected at about the current level.

Government grant revenue is recognized to the extent of grant expenses. Amounts recorded as grants receivable are for grant expenses incurred in advance of the receipt of grant funds. Funds received in advance of grant expenses are recorded as deferred income, and separate restricted bank accounts are maintained in connection therewith.

Included in government grant revenues and expenses in AARP's statement of revenues and expenses is the value of time spent by the grant host agency site supervisors and certain facility and supply costs. These contributed services are valued at rates permitted by the grants. Such services and costs amounted to $6,206,000 and $5,348,000 in 1988 and 1987, respectively.

AARP Insurance Plan: The AARP Insurance Plan (the Plan) was established by an Agreement and Declaration of Trust for the purpose of providing group health insurance to AARP members. The Plan is administered by Trustees consisting of members of AARP appointed by the Board of Directors of AARP.

Group health insurance is provided under an agreement with the Prudential Insurance Company of America (Prudential). AARP receives administrative allowances based upon payments received by the Plan from insured members. Such payments received by the Plan for the years ended December 31, 1988 and 1987 aggregated approximately $1,933,000,000 and $1,727,000,000, respectively.

The Plan also earned interest from the investment of funds representing payments received but not yet remitted to Prudential. For the years ended December 31, 1988 and 1987, interest earned by AARP from such investments amounted to $19,460,000 and $15,463,000, respectively.

Continued on next page

Continued from previous page

Income from Other Programs and Services: Retired Persons Services, Inc. (RPS) is a separate unconsolidated entity sponsored by AARP, which operates twelve pharmacies across the United States, primarily for the benefit of AARP members. RPS pays royalties to AARP.

AARP sponsors a program of automobile and homeowners insurance coverage provided by The Hartford Insurance Company, resulting in royalties to AARP.

Travel-related services include AARP-sponsored car rentals from Avis, Hertz and National Car Rental companies. AARP also sponsors AARP Motoring Plan, which is provided by Amoco Enterprises, Inc. and AARP Travel Service which is provided by Olson-Travelworld, Ltd. and R.F.D., Inc. AARP receives royalties from these programs based on services provided for AARP members.

AARP also derives income from AARP-operated educational programs, such as preretirement and driver improvement programs.

Operating Expenses: Details of operating expenses are as follows:

	1988	1987
Salaries	$ 34,049,000	$ 28,930,000
Payroll taxes and employee benefits	7,341,000	6,816,000
Post-retirement health care benefits	1,975,000	6,851,000
Printing	58,777,000	50,637,000
Postage	52,362,000	46,980,000
Program support	10,329,000	9,571,000
Membership solicitation	8,407,000	7,272,000
Publications support	4,661,000	4,508,000
Office expense	4,904,000	4,348,000
Data processing	4,604,000	4,801,000
Rent	8,314,000	7,618,000
Staff travel	3,354,000	2,610,000
Expenses of national officers and volunteers	8,460,000	7,286,000
Telephone and utilities	1,549,000	1,540,000
Professional services	2,432,000	3,146,000
Public relations	7,003,000	6,024,000
Personnel administration	930,000	705,000
Board meetings and biennial convention	2,957,000	974,000
Nursing and retirement homes	292,000	312,000
Depreciation and amortization	3,830,000	3,286,000
Miscellaneous	1,331,000	1,280,000
Total operating expenses	$227,861,000	$204,695,000

AARP Federal Credit Union: AARP sponsors the AARP Federal Credit Union (Credit Union) which provides financial services to AARP members. The Credit Union was granted a charter in 1987 and commenced operations in 1988. Service Company has entered into an agreement with the Credit Union and AARP for the provision of certain oversight, membership development, investment management, processing and administrative services on behalf of Credit Union. Service Company has agreed to advance specified sums on behalf of Credit Union for the cost of such services. The agreement provides for contingent payment of such advances by Credit Union only upon the achievement of specified operating results by Credit Union. Service Company simultaneously entered into an agreement with AARP, Credit Union and two unaffiliated entities, for the provision to Service Company of these membership development, investment management, processing and administrative services. AARP and the two unaffiliated entities have agreed to advance specified amounts on behalf of Service Company for the costs of such services. The agreement provides for the contingent payment of such advances by Service Company only upon the achievement of specified operating results by Credit Union. At December 31, 1988, Credit Union had not yet achieved the required operating results, which are the same for both agreements, and no such amounts were payable by Credit Union or by Service Company. At December 31, 1988 amounts advanced by these entities to Service Company, plus accrued interest (including $2,532,000 advanced by Financial Services) which may be subject to contingent payment in the future, approximated $15,300,000. It is not now possible to predict when, if ever, such amounts might be repaid. Amounts advanced by Financial Services through December 31, 1988 have been charged to expense.

Health Care Benefits: AARP provides certain health care benefits for active and retired employees, who meet current requirements. Substantially all of AARP's employees may become eligible for these benefits if they meet the applicable requirements while working for AARP. Health care benefits for active and retired employees of AARP are provided through the AARP and RPS Employees' Welfare Trust.

The Trust receives contributions from participating employers to provide for current benefits based on expected costs of the Trust. For the year ended December 31, 1988, AARP contributions to the Trust for current health benefits were $3,505,000. In addition, during 1988, AARP accrued $1,899,000 relating to the projected cost of providing post retirement health care benefits for active and retired employees.

Pension Plan: AARP participates in a multiple-employer noncontributory pension plan covering all employees after they qualify as to length of service. Plan assets, administrative expenses, and expected contributions have been allocated to AARP in proportion to the projected benefit obligation. AARP's general funding policy is to contribute an amount equal to or greater than the minimum funding requirements of ERISA, but not greater than the maximum deductible limit for taxable entities.

The following tables detail the components of net pension expense, the plan's funded status, and the amount included in AARP's balance sheet.

Net pension expense components for:

	1988	1987
Service cost	$ 1,579,000	$ 1,667,000
Interest cost	1,488,000	1,305,000
Actual return on plan assets	(1,417,000)	(2,532,000)
Deferred net asset gain	(187,000)	1,115,000
Net pension expense	$ 1,463,000	$ 1,555,000

Balance sheet components at December 31:

Fair value of plan assets	$23,576,000	$22,546,000
Accumulated benefit obligation:		
Vested	(13,992,000)	(10,617,000)
Nonvested	(849,000)	(947,000)
Provision for future salary levels	(7,230,000)	(6,641,000)
Assets in excess of projected benefits	1,505,000	4,341,000
Unrecognized net gain	(2,006,000)	(3,392,000)
Prepaid pension expense (pension liability)	($ 501,000)	$ 949,000

Major assumptions used at December 31, 1988 and 1987, respectively, were: discount rate of 7.75% and 8.25%, expected long-term rate of return on plan assets of 8.0% and 8.5%, and salary increase of 5.7% and 6.7%.

Commitments and Contingencies: AARP has contracts for production of Modern Maturity, its bi-monthly magazine, and the monthly AARP and NRTA News Bulletins. The contracts are based upon minimum press runs, with annual printing costs of approximately $52,800,000 for Modern Maturity and the AARP and NRTA News Bulletins. The publications contracts also contain certain provisions for price escalations due to increased paper, labor and other operating costs. The contracts are cancelable upon termination of the publications or by 24 months written notice by either party but not before completion of the April/May 1993 issues.

AARP maintains office and warehouse facilities under long-term operating leases. Future minimum rental commitments, exclusive of additional operating costs and net of minor subleases in effect at December 31, 1988, are $8,136,000 in 1989; $7,777,000 in 1990; $7,579,000 in 1991; $7,269,000 in 1992; and $6,491,000 in 1993. For years 1994 and thereafter, total commitments are $26,428,000.

In addition to existing lease commitments, AARP has entered into a twenty-year operating lease for new office facilities in Washington, D.C. which commences in 1991. The minimum base rental commitment during the initial term of that lease, exclusive of additional operating costs, cost of living adjustments or other incentive adjustments, will be approximately $14,000,000 annually beginning in 1992. That lease can be rescinded under certain circumstances prior to occupancy including the failure of the owner to meet certain completion deadlines.

Dr. TODD. You have to believe there is a problem, sir.

Mr. PICKLE. But I also say to you, that if we get into this field, that means that medicine, AMA, has got to bring something to the bargaining table to be sure that we do have good medical practice and that it is not due to any negligence.

You have got to be more aggressive either in certification or finding a program whether it is on a State level or some other level to show that you are doing what is proper. And the insurance people have got to stop complaining that there should be no limitation on these figures when you consider the fact that the insurance company is making more than 15 percent on some of their rates.

I do not think that is a very stable position to be taking and the insurance companies complain that they are doing nothing more than just charging what the market bears.

It seems to me, Mr. Chairman, that there is a kind of a plague on all the houses in this field. Now, I am not sure that I know what the answer is, but I think it is a situation that does cry for some kind of recommendation, either from the Congress or from the States, or within the associations. I think the American people are entitled to some relief.

I think this hearing is good for the purpose of pricking our thoughts and bringing our attention to what is the answer? I hope that we can do it, but I only think we will do it if we work cooperatively and not try to protect our own little territory, because you are all at fault and so is the Congress too, at not trying to find a better answer. I think that is our challenge, Mr. Chairman.

I thank you.

Mr. COYNE. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

I appreciate the input of this panel and as to the testimony of the Trial Lawyers Association, I think you do define very narrowly the issue of cost. What really is driving us here today, and I think what has raised this concern nationally, is not the cost of premiums or the cost of awards, though a lot of people have a lot of problems with both of those things.

It is that if we are going to create a medical health care system in which everyone has access, we have to do something about rising costs, and when you look at rising costs, some people estimate that as much as $30 billion of today's costs are the consequence of defensive decisionmaking by practitioners.

While I do not swear by the figure of $30 billion or any other amount, anyone who is out there—I represent 45 towns; I represent about 8 hospitals; most of them small; I represent a lot of providers—you cannot be out there with a constituency the size of ours and not hear over and over and over again, of procedures recommended, studies done, so on and so forth, that clearly are not the consequence of wanting to make sure that the entire landscape is surveyed.

So I think your narrow definition of costs is irrelevant to our discussion. Your concern about rights is certainly one that all of us share. The problem is that the current system denies the rights of the majority and particularly disadvantages senior citizens.

That is evident from the data. I would hope that you would begin to look with us at alternatives, for those the current system is not

serving. I do not propose my bill saying this is the answer, but it is a point at which we can begin to recognize that there are options in our world that honor the competing rights of all those in the system.

So I cannot help but say I am disappointed in your testimony and I look forward to working with you, because in the end, we must get something that all segments of our society can feel is an honest effort to move into the future.

There are two issues I would like the panel to discuss at some greater length, because they are of great concern to the members of this subcommittee. One is the "bad doc" problem and one is the trust issue.

For years, it was held that the cost and the threat of malpractice had no impact on access. That is no longer arguable any more. In the last few years, it has become absolutely evident that access and liability are related and that extraordinary liability and an irrational liability system can, and does in fact, reduce access.

It has been raised by several members of the panel, that, in fact, the legal environment in which health care is currently provided does affect the relationship between doctor and patient.

In the end, health care depends on the quality of that relationship more than on any other factor, because the process of diagnosis is so incredibly complex, un-cookbook like for the most part. Those cases that end up with problems had problems to begin with, problems with complexity. In those situations diagnosis is very difficult. Trust is critical. The biggest mistakes are made when there is a lack of communication.

So, I would like to hear more of your analysis of why this is affecting that relationship and on what basis you say it is affecting it, because I think it may be one of those problems like the access problem, it may be a couple of years before we understand what it has done, and by then, it will be hard to correct the problem.

The flip side of that is how do we deal with a "bad doc" problem? Clearly, State boards have not done a good job. Professional associations have not done a good job. We have tried, in Medicare, to penalize folks who we think are not doing a very good job, but this is an area in which we, as a society, need to do a better job. I wonder what are some of the new things that are happening out there, that you see as promising in terms of this issue of identifying early the inadequate providers, either educating them or getting them out of the system?

I am just asking what is working, what should we be looking at in terms of the bad doctor problem, and how serious do you think the erosion of trust really is?

Dr. TODD. Well, Representative Johnson, let me try and start by answering the second question first. I believe that Mr. Fager will agree that there is no clear relationship between a physician's competence and the incidence of malpractice. Some of the most competent physicians in this country, by virtue of the complexity of the work they are doing, by virtue of moving the frontiers of medicine forward, do indeed engender a considerable number of suits.

In retrospect, they can be found to have done something differently than they might have done. I think we need to dispel the

notion that the "bad doctor" and the liability issue are parallel. They clearly are not.

Regarding the "bad doctor" problem, the medical profession is limited in its ability to deal with bad doctors by actions of the Justice Department and the Federal Trade Commission. On the other hand, we have supported, since 1966, increased funding and increased personnel for State licensing boards. We have prepared physicians' committees in 50 States of this country and we have agreements with most of the State licensing boards that if a physician is impaired by substance, age or other means, and if rehabilitation is possible, it will be done in cooperation and with the understanding and knowledge of the medical board.

The Federal Government has been involved in the quality issue, as you know, very deeply. The PRO program, which is actual in all 50 States, rejects less than 2 percent of the cases as involving inappropriate or unnecessary health care. Hospitals have their own peer review mechanisms they use, and they use them relatively well.

Medical societies used to be able to adjudicate fee and competency problems prior to the intervention of the antitrust problems. And in terms of professional liability, there is not a State medical society in this country that is without access to risk management tools. As I testified earlier we have 32 national medical specialty societies that have been working together voluntarily since 1986, and have produced a whole series of material for physicians to use to identify the areas of greatest danger and to try to eliminate them.

You heard the testimony from the GAO that the anesthesiologists have demonstrated that risk prevention and risk management does work. Mr. Fager and the PIAA companies are very zealous in underwriting physicians whom they insure and if they have reason to believe these physicians are substandard or need remedial activity, they are not slow to recommend it, including either denial of insurance and/or practice audits.

Mrs. JOHNSON. You mentioned in your testimony, doctor, the fact that you help to pay litigation expenses incurred by medical societies or their members in discharging this responsibility.

And then you go on to say that the threat of litigation is a factor that has chilled action of this nature in the past. How serious has that threat of litigation been for those who would enforce higher standards or would go after the nonperformers?

Dr. TODD. We believe that that threat is a very real one to the physicians performing the peer review. We are hopeful that the physicians national practitioner data bank will help to reduce some of that liability. But if the only reward for a physician sitting on a peer review committee, reviewing credentials or trying otherwise to rehabilitate or reeducate an aberrant physician, is a lawsuit, it is unlikely that physicians are going to participate in this activity in great numbers, particularly when they are primarily responsible for defending themselves.

Mrs. JOHNSON. And so do we need to provide some immunity from suit for reviewers?

Dr. TODD. Absolutely. Peer review needs to be strengthened and broadened, and it needs to have increased immunity from suit. Of

course, immunity should be granted only for good faith peer review. When appropriated, immunity for peer review is essential—so much good peer review today is not being done because of the fear of the consequences of a suit, and I speak from personal experience.

Mrs. JOHNSON. Thank you.

Comments from any of the other members of the panel?

Mr. FAGER. Mrs. Johnson, if the Chair will permit me one anecdote on this very issue, we discovered a doctor who had a number of claims and his peers reviewed his cases and were seriously concerned about the standards of practice, and recommended that his insurance coverage be not renewed. At about the same time, his hospital privileges were suspended and he sued the peer review doctors at the hospital.

Going back to earlier days, when we took that action, we found that doctors who were not renewed simply went across the street and bought their insurance some place else. That was a concern to the doctors who ran our program.

In New York, we asked and obtained legislation that required us to report such cancellations or nonrenewals to the Board for Professional Medical Conduct. That does not mean that every doctor whom we cancel should have his license taken away. It does mean that the disciplinary authorities should have that fact, I think, brought to their attention.

Mr. HERMAN. Representative Johnson, I would like the opportunity to respond to the two questions. First of all, though we come from a different point of vantage, I do want to applaud you for bringing forth a proposal and you obviously have put your finger on legitimate concerns and have approached it legitimately.

Our constituencies differ so that we do have some difference of opinion, but I think the questions that you ask are important, and I know that you are seeking from us, at least, our perspective. I do not believe that there is such a thing as a "bad doctor," in this situation. What we are looking at is human beings who are negligent; some of them less competent than others. The very term, malpractice, which means evil practice, and bad doc, we have got to eliminate those expressions. I can tell you that the plaintiffs' bar is working very hard to eliminate these expression to eliminate the expression, malpractice, because mal means evil and also, bad doc. Just the language we use is inflammatory.

Let me speak for a moment about the legal environment in which medicine is practiced. Most proposals indicate that there ought to be a limit on what an injured person can recover for their pain and suffering, a loss of enjoyment of living.

That immediately cuts off all children and all senior citizens from fair compensation. The children do not have economic damage. The senior citizens, mostly, are retired and are either on pension or fixed income. And if all they are limited to is an arbitrary figure, then they are not being fully compensated. That is a legal environment and how the practice of medicine gets tangled up in these legal rights, I do not know. Medicine ought to be practiced in the arena of medicine and, unfortunately, we have not been able to separate the economic impacts.

When I speak about the limitation of rights, what I am saying is that every individual in society ought to have the same right as every other individual. Thus far, there has been no alternative system proposed in which the victim, who is innocent after all—we are assuming that the victim has been negligently treated— no system has been proposed where every victim is treated like every other victim under the legal system.

Now, the legal environment does cause problems that lawyers are responsible for. Lawyers that do not screen cases properly; lawyers who take cases without understanding that many cases, many, many cases are due to lack of proper communication between patients and physicians; these lawyers can cause and do cause a burden on the system.

But that burden is minuscule when compared with the overwhelming costs incurred—and again, and I have to get back to it—by over-bedding; a cost which is many, many billions of dollars and it is not anecdotal, it is confirmed by studies.

There has been no recent study. We would like to see one.

Mrs. JOHNSON. I am sorry, I did not get that, over what?

Mr. HERMAN. Overbedding. In other words, so many hospitals have been issued——

Mrs. JOHNSON. Overbedding?

Mr. HERMAN. When you cannot fill all of the hospital beds, the cost of a single bed increases. That this whole question of who controls the laboratories——

Mrs. JOHNSON. Yes, but we could argue about those, as the length of stay decreases, the cost per day increases. The occupancy rates are a subject of great controversy.

Mr. HERMAN. Those are legal questions also because the whole admitting process for hospitals, the whole process of lab certification and lab charges are legal processes. When we speak about the legal environment in which medicine is practiced, we are not just speaking about a potential court environment that involves a personal injury, but the whole system is impacted.

Mr. AMSDEN. Congresswoman Johnson.

Mrs. JOHNSON. Yes.

Mr. AMSDEN. I would like to comment with respect to your question.

You referred to it as the bad doc issue and I guess I would refer to it as the medical practitioner whose competence has been called into question. In the written testimony that I have offered the committee, we speak about quality controls and risk management. AARP has long been talking about the fact that hospitals ought to be very certain that they check very carefully into the credentials of that individual that they are bringing into their hospital, his licensing, his past experience practice and so forth.

We are also talking about peer review, as Dr. Todd mentioned. We are also encouraging that physicians do thorough consultations with other practitioners about management of a case. I am sure you are also aware that many third party payers are now requiring second surgical opinions as a means of helping the patient, as well as the physicians to be more careful in documenting the situation with that patient.

And you mentioned something about trust and the trust relationship. If I could, I would like to simply say that we could supply you with an awful lot of publications in which we say to consumers, you should do all of these things when selecting a physician and you should do all of these things after you have selected that physician and these are the kinds of questions you ought to be asking of your physician and this is the kind of information that you ought to be telling your physician, and so forth.

I am certainly one of those who believes that most people select a physician at some point in their life, maybe in their 20's or early 30's and they are likely, as long as they remain in that area, to ride with that physician until the day that that physician retires.

And then they may find themselves at age 60, suddenly looking for a new physician and having not the faintest idea of where to go or what to do and they are really quite frustrated and they may go without a physician for a while.

But the point I am really trying to make is that generally most people have basic trust with physicians and hope that they have selected wisely. Unfortunately, as the gentleman to my left has pointed out, there are individuals who, from time to time, make errors of judgment and sometimes that judgment can be very painful.

Mrs. JOHNSON. I appreciate your getting on the record a lot of the changes that have been adopted in the last 3 to 8 years that have improved our ability to identify problematical practices, and to develop judgment in the direction that we want to see it go.

I do think that there are some continuing problems and I think immunity of reviewers is a very serious one. On the other hand, you have to give appeal beyond that, but I think that there are some things that we need to look at and I would be most interested in thoughts that you have on that subject.

Thank you, Mr. Chairman.

Dr. TODD. If I might, Mr. Chairman, I think we need to separate the issues of doctor performance and competency and monitoring from the issue of the failure of the tort system to do what it is supposed to do. In the recently reported Harvard study, 80 percent of the patients that sued their physicians were found not to have any negligent injury and some of them not any injury at all. On the other hand, only a very small percentage of those who had received negligent injury got into the system. We, as a profession, want to see those who are injured as a result of negligence promptly and fairly compensated but we do not want to have to spend billions of dollars investigating and defending merit less cases.

Mrs. JOHNSON. Thank you, yes, that is a very important point.

Mr. COYNE. Dr. Todd, your testimony suggests that there are not really any bad doctors, just unlucky ones. This seems to be an accident can happen to anyone type of characterization to the problem.

Mr. Herman, your testimony indicates clearly that you think that malpractice injuries are due to a few bad apples that could and should be weeded out. I wonder if each of you could comment on the other's testimony. I assume the truth probably lies somewhere in between?

Dr. TODD. Well, Mr. Chairman, if our testimony gave the impression that the medical profession was perfect, then I would want to

change that immediately because there is no perfection in this world.

On the other hand, we have no way of adequately or competently knowing what the level of incompetent, impaired physicians are. All we can say is that we are working diligently to identify them, rehabilitate them, reeducate them, and in the extreme, eliminate them from the profession if necessary.

A very important point, however, that must be borne in mind, is that some of the greatest physicians in this country, some of the most competent physicians in this country, because of the nature of cases with which they are dealing, not infrequently find themselves on the short end of a lawsuit. For example, 73 percent of the obstetricians have been sued. And 73 percent of the obstetricians in this country are not incompetent, they are not careless and in many instances they may have been victims of circumstance totally beyond their control.

Now, in addition, physicians not infrequently are forced to make decisions, important decisions in a matter of minutes, with inadequate information, in the middle of the night with no way of getting vital information, and then the legal system has anywhere from 8 to 10 years to dissect those decisions. In retrospect, it is very easy to say, perhaps it might have been done a different way.

Mr. COYNE. Mr. Herman.

Mr. HERMAN. I have always believed: first truth and then justice, and you do not get the truth in a closed society. And the truth is, Mr. Chairman, whether America is willing to realize it or not, physicians have created a closed society in which physicians judge physicians' conduct. You do not have people who have been negligently injured going into court when the secrets have been locked up in peer review committees that are not open to public scrutiny, when they are locked up in incident reports and hospital reviews that are not open. When the patient as a matter of practice is not notified that he has been negligently treated, that patient may have no recourse but to seek the courts.

And it seems to me it is a pretty good system. If what the physicians contend is that the juries have found them not negligent when they are not negligent, then it seems to me that is a system that is fair.

I do want to say to you, however, that I do believe that only 10 percent of the physicians are liable for approximately 80 percent of the negligence. I do not say that anecdotally and I do not pull it out of the air. There was a study in Florida and a study in Pennsylvania and those figures were generally confirmed by both authoritative studies.

We know right now that if the Harvard Medical School went into every major hospital in the country you would know what doctors are creating the most negligence, it is right there in the records.

The fact is that secrecy in the courts is bad, secrecy in the hospitals is bad. As this body legislatively moves to more and more disclosure and sunshine, the professions have gone the other way and closed in. And I mean all professions, including the legal profession. Once the truth gets out, things improve.

And there are so many mechanisms set up to shield the negligent doctor, lastly. There are some physicians, just as there are

some attorneys, and there are some engineers, or some taxicab drivers, or some individuals performing some services that they should not be allowed ever to perform. The problem is the secrecy.

In Ohio, the "love physician" who has covered up—well, I do not want to mention the name of the hospital, because it is hidden in court documents that have been closed. Women were called "material." The doctor called the women that he treated, "material." They knew what he was doing, there is no reason why these secrets have to be buried. Of course, there is going to be distrust. When there is no open disclosure there is distrust. And the more closed-in we become, the more distrust there is, not just in medical matters or legal matters, but in all of life.

So I say to you, yes, there are very few bad docs, and there are physicians who make mistakes just like everybody else makes mistakes in this society, they are accountable for the fault that they cause or should be. I also say to you that there are some people who should not be practicing medicine and unfortunately the system does not weed them out and I do not, on behalf of the victims we represent, intend to apologize for asserting their rights in court, because I believe they are innocent. I do not believe they are responsible for escalating the costs of the system and I do not believe they ought to be penalized in the process.

Mr. COYNE. Dr. Todd, I will direct this question to you but any of the panelists are welcomed to respond. Why do malpractice suits not lead to more disciplinary actions by State licensing boards and hospital staffs?

Dr. TODD. Well, as I said earlier Mr. Chairman, the loss of a malpractice suit may not have any relationship to the competency of the individual who was sued. The doctor-owned insurance companies have done an extremely good job—and I would let Mr. Fager answer this question also—in reviewing cases that come before them. Many of them have remedial programs. An instance of negligence may be the only lapse in that physician's entire distinguished career and the physician may need a practice audit, some reeducation, and to see some of the risk management data that the insurance companies have been collecting. But I think it is wrong, in fact, I know it is wrong, to equate malpractice with the competency of the physician. They are really two different things.

We have found, over and over again, that malpractice suits in general tend to occur randomly. Now, obviously, there are instances in which that is not true, but in general, you cannot predict based on competence or mode of practice or anything else, who is going to be sued. I would ask Mr. Fager if he would like to expand on that?

Mr. FAGER. Mr. Chairman, I would like to direct your attention, I did it in my written testimony, to a particular kind of case, the dreadfully unfortunate emotional case of the infant with cerebral palsy, and the lawsuit against the obstetrician and the hospital and sometimes the family practitioner and the anesthesiologist.

Now, these cases are fraught with tremendous emotion and understandably juries react that way to them. But the scientific evidence—and the National Institutes of Health have done studies on this—shows us that most of these unfortunate cases have nothing

to do with doctor care either before, in labor or delivery or post-delivery, nothing to do with it.

And yet, we find big, big verdicts against doctors in these cases. Now, we studied these cases nationally through PIAA to see what we could find out. The first thing we found out was that about 75 percent of these cases were in the hands of doctors with the highest credentials, board certified obstetricians with years and years of training.

And so there is no, I submit, no real relationship between the bad doctor problem and the monumental problem of liability as we know it. I do not mean to suggest that there are not bad doctors and we must be continually vigilant to identify them and do everything we can on the public's behalf where those bad doctors are concerned.

Mr. COYNE. Would anyone else like to comment on that question?

Mr. HERMAN. I would like to comment on it.

I do not like blaming special children for a problem. Now, the fact is that many OB's in this country still inject oxytocin to speed up birth. It is supposed to be dripped. But they still inject it and because they inject it, the head of the fetus pounds against the cervix. And there are still fetal monitor strips that are being destroyed in hospitals, and there is still the lack of use of internal and external fetal monitor strips to determine when a fetus is in distress.

We know that you can run special tests to determine whether or not these special children have been victims of negligence in the hospital or whether or not they have inherited some problem. There are tests that are run in these cases.

You do not blame the young, special child for the negligence of the physician, and it is not right to do it. These cases are real. You are never going to get at a problem by sweeping it away. You cannot explain to a young mother who learns the truth 3 years after the negligent insult why it was never reported to her in the first place. And to say that there are no cases of special children caused by medical negligence at birth is not only—it is just plain wrong.

Again, the whole emphasis in the debate is about physicians and the income of physicians and insurance premiums. The whole focus is on changing the law, and the only—there is not—none of the victims of medical negligence are present here, at the table. The National Insurance Consumer's Organization representing the consumers of insurance, is not represented and what I say to you is that we cannot ignore the fact that there is negligence. As long as we continue to wrap ourselves in secrecy, we are going to continue to have a serious health problem, and distrust is going to feed it.

Mr. COYNE. Thank you.

Mr. Moody.

Mr. MOODY. Thank you, Mr. Chairman.

I gather that Dr. Todd and Mr. Fager believe that there is no correlation between malpractice and negligence, or between malpractice and competence. Is that what you just said, a minute ago?

Mr. FAGER. I think what I said, sir, was that there are certainly indications and cases where malpractice and recoveries are due to negligent conduct and negligent physicians. What I said is that the

problem as we know it, in all of its aspects, as I see it, is not a bad doctor problem.

In other words, we have the highest risk doctors, neurosurgeon, obstetricians, orthopedists paying the highest rates and other doctors, in other specialties paying much lower rates and my point is that it is not because they are bad doctors, but because of the work they do and the risk inherent in their procedures, but not for 1 minute to deny that there are negligent doctors who do cause injury, yes, sir.

Mr. MOODY. Well, no, my question is, within a given specialty does incidence of malpractice suits correlate with incompetence or competence?

Mr. FAGER. Not necessarily. I think we have to look at that very carefully in each case as we tend to do. We have a setup which tells us that a doctor has more claims than the average for his specialty, that causes us to look directly at those claims to see what kind of medical practice he is rendering.

We find, in some such cases, that the doctors are administering good, acceptable medical practice.

Mr. MOODY. Is it that they have just been unlucky again and again?

Mr. FAGER. No, there are some where certainly there are departures from proper practice.

Mr. MOODY. Now, that is my question.

Mr. FAGER. Yes, sir, no question.

Mr. MOODY. Are you correlating the frequency of malpractice? I do not mean any one case or any size of an award but does the frequency for any one doctor for malpractice claims inversely correlate with competence?

Mr. FAGER. For any one doctor?

Mr. MOODY. Yes.

Mr. FAGER. No, sir.

Mr. MOODY. It does not?

Mr. FAGER. We cannot say that it does, it may in some cases, but it does not necessarily.

Mr. MOODY. Well, not necessarily, but does it tend to correlate in the statistical sense a frequency variable?

Mr. FAGER. The frequency is something that must be carefully examined.

Mr. MOODY. Well, that is what I am asking. Have you examined it?

Mr. FAGER. Yes, sir.

Mr. MOODY. What did you find?

Mr. FAGER. We find that in some cases it is the result of the kind of practice the doctor is engaged in. At some of your leading institutions in this country, where doctors are taking on heroic work, they are much more liable to have problems and they are much more liable to suit.

It is not a direct relationship to incompetence, by no means.

Mr. MOODY. I did not say it was the main variable. The main variable is clearly the skill it may be other things. I am saying, holding those variables constant, if you do a multivariable analysis, do you think that isolating the variable of frequency of malpractice

claims against a doctor allows you to infer anything about his competency?

Mr. FAGER. I can only say that it requires additional investigation. The mere fact of frequency, sir, in and of itself, I cannot correlate.

Mr. MOODY. Even in a large number of cases——

Mr. FAGER. It depends on what number.

Mr. MOODY. Or any one doctor, obviously. Has anyone done the study with real statistical——

Mr. FAGER. I can tell you, maybe this will be of some help, the health department in New York, tried to correlate reports of claims and incompetence within the professional discipline because they have all the malpractice claims too, and they found that there was no corelationship between malpractice claims and medical disciplinary problems until you got up to six or more claims.

At the six or more claim level, they found that 25 percent of those doctors had been involved in some sort of disciplinary incompetent——

Mr. MOODY. But does the disciplinary incompetent grow out of some other event or does it grow out of——

Mr. FAGER. That was not clearly defined in the study.

Mr. MOODY. That is crucial.

Mr. FAGER. Yes, sir, you are absolutely right.

Mr. MOODY. If a disciplinary action grows out of the very frequency of malpractice that I am asking you about then obviously they are correlated because one triggers the other.

My question is, has anyone tried to correlate competence with frequency of malpractice claims?

Mr. FAGER. Yes, that is the only study that I am aware of and it lacks the credibility that you suggest. The effort was to see how many doctors that were incompetent on some basis had some relationship with doctors who are multiclaim physicians.

Mr. MOODY. Right.

Dr. Todd, do you want to comment.

Dr. TODD. Yes. I think intuitively you have to believe that if a physician has an aberrant claim record, he is generating more claims than his peer—you have to assume that physician is doing something different. Now, it may be an attitudinal matter, and trial attorneys tell me that most patients that they see are not injured, but they are angry and that will sometimes——

Mr. MOODY. You mean attitudinal on the part of the doctor or on the part of the victim?

Dr. TODD. In terms of the patient, who feels he or she has not had the amount of attention that he or she deserved, or the office sent the bill to a collection agency or a whole number of things that have no relationship to competence or negligence whatsoever.

Mr. MOODY. But people do not put themselves through the agony of trial just because they are angry, do they?

Dr. TODD. Most of those cases do not get to trial, they get settled long before the courtroom, but they cost a lot of money to investigate and defend and it is a lot of money spent both by the trial bar in deciding if they are going to take the case in the first place, and a lot of money spent by the insurance companies in trying to settle the case.

But what the doctor-owned companies have done, and I suppose that we can probably get this information if we were to do the study, is that when a physician has an aberrant practice pattern, that physician is studied by the underwriting people of the insurance company. These studies have not shown a clear correlation between numbers of cases and competence.

The Florida Study that was just referred to——

Mr. MOODY. Wait a minute. Let me just back up. They have looked at it and cannot correlate the frequency of serious malpractice claims that go to trial. They cannot correlate that to medical competence. Is that what you are saying? They do not experience rate doctors? They do not charge people who have been in court six times any higher malpractice fees than someone who has never been in court? Is that accurate?

Dr. TODD. Well, it is difficult to experience rate, because a physician may go for 20 years and never have a suit and therefore, pay a very low rate, if you are going to experience rate them and then have a blockbuster and——

Mr. MOODY. That does not mean that you cannot experience rate them. I drive my car for 20 years and have no accidents, I do get a better insurance rate than if I have six or seven accidents and four or five speeding convictions.

I may have no accidents for 20 years and then have a huge blockbuster but I still get experience rated because there is 20 years of practice to go on.

Dr. TODD. But it is much easier to do on automobile insurance than it is to do in professional——

Mr. MOODY. Well, I am asking you, do any insurance companies experience rate the physician? Not the specialty, since we know the specialty has to be experience rated, but the physician himself or herself?

Dr. TODD. Well, most insurance companies do impose surcharges upon physicians who have excessive claims rates.

Mr. FAGER. If I can help Dr. Todd with that question, sir. They do, in many cases, surcharge or rate doctors. There are some companies around the country and some joint underwriting associations that have standard formula, which say that if you have *x* number of claims——

Mr. MOODY. Well, it seems to me that if insurance companies are experience rating doctors, then, that itself is the opposite of the conclusion that you drew a minute ago, that they cannot tell. They are making a determination that this doctor is higher risk for something inside the doctor's head, not because of the specialty he is in that distinguishes him from other doctors in the same specialty that makes him or her a higher risk for the future. They cannot go back and change the past.

Mr. FAGER. Yes, sir, but the words you used were incompetent. If we thought he were incompetent, surcharging would serve no useful purpose at all. We would not want to provide coverage for him or we would not want to provide coverage for areas of incompetence.

Mr. MOODY. Incompetence is a shorthand term. Let me just finish——

Mr. FAGER. I am sorry.

Mr. MOODY. Shorthand, the word, incompetent, I do not mean that he or she is grossly incompetent, but subject to action by the patient.

Mr. FAGER. Yes.

Mr. MOODY. Something they do subject to action. Patients do not normally go for action if they feel happy and satisfied with the results, do they?

Mr. FAGER. Yes, sir.

Mr. MOODY. OK.

Mr. FAGER. In the early days of our company we were surcharging and we were not permitted by the regulators at that point to cancel doctors. We surcharged one doctor, and he was paying a premium of $80,000 that was unheard of in those days. And the chairman of our board said, do you know what we are doing, we are simply forcing this man to perform more unnecessary surgery to pay the premiums we are charging him. That does not help us or society at all.

Mr. MOODY. I have two kinds of questions and I will try to brief.

Now that you have permission to cancel, yank insurance, how often does that happen?

Mr. FAGER. We cancel, I would say 15 to 20 doctors on annual basis, I am talking about our New York company now where I have direct experience.

Mr. MOODY. That does not help me, I need percentages.

Mr. FAGER. Oh, that is out of 15,000 doctors.

Mr. MOODY. So what percentage is that, one-thousandth of 1 percent?

Mr. FAGER. Yes, something like that, it is a very small percentage.

Mr. MOODY. The relative ratio of inappropriate medical practice we have heard so far, far exceeds that ratio, so maybe there is something out of line here. I want to call on the gentleman from the trial lawyers in just a second.

But Dr. Todd, would you respond to two quick questions? First, do you think that the procedures are adequate for disqualifying, removing or delicensing through the insurance mechanism or through this certificate mechanism, those doctors who are indeed less than fully competent?

Dr. TODD. When properly implemented, yes. Part of the problem is that, at the moment, there are State boards that are underfunded. There are also due process concerns that need to be addressed. Not infrequently, a physician can be brought in before a licensing board for a licensing activity, and a good attorney can string the activity out for years. We need to strengthen the mechanisms, or the implementation of the mechanisms, we believe those mechanisms are, indeed, in place.

Mr. MOODY. Second, Dr. Todd, before I turn to the trial lawyer, what about Mr. Herman's point that there is tremendous secrecy and that consumer information is scarce and therefore, some of these problems are derivative of that? Is his statement accurate about the secrecy?

Dr. TODD. It is certainly not as accurate as it used to be, there used to be the veil of secrecy. We now have physicians willing to testify, and indeed sometimes we have more attorneys than the at-

torneys can use. On the other hand, as we have said, it would be very difficult—and we do not have any problems with giving adequate information, appropriate and relevant information, that the patients can use in making their decisions. But if we have agreed that a malpractice suit is not necessarily a measure of competence, and that——

Mr. MOODY. But it may be.

Dr. TODD. It may be, but until such time as you can document that correlation, is it appropriate to besmirch the reputation of a good physician to destroy the trust that we were talking about earlier? A patient may have been going to this physician for 20 years and may have had a perfectly fine relationship and then all of a sudden some piece of information is put out that this man just lost a malpractice suit. Think what that does?

Mr. MOODY. I do not think that is the information that Mr. Herman is referring to. He was talking about records, inside records. If I heard him right, he was not talking about the results of court action, that is not the secrecy that you are concerned about, is it, Mr. Herman?

Mr. HERMAN. You are quite correct, Congressman Moody. What I am concerned about is that peer reviews, infectious disease reports, internal reports, incident reports of hospitals are not revealed to the patients directly so that they know why they have been injured and how it was that they became injured.

Mr. MOODY. Let me just stop you here. Dr. Todd, do you want to respond to that?

Dr. TODD. Well, as I say, we are not opposed to the appropriate relevant information being given to patients, but to give a patient a medical record, would presuppose that they are going to be able to understand what is in there.

We believe and believe very strongly that the average physician, the good physician, no physician wants to be negligent, and no physician wants to harm.

Mr. MOODY. No, we all know that, and we all agree with that. There is no question about that.

Dr. TODD. And we believe that these physicians will talk to their patients and will tell them to the best of their knowledge. Many times, even a jury has trouble deciding whether negligence occurred and that is why physicians are not always willing to run down and say, well, I think I did something that harmed you.

But my experience has been when a bad event has occurred, when the patient and physician move together to try and solve that problem we do not see a great deal of litigation. Physicians are not perfect, and they are never going to be perfect. We are going to try and keep working to make them as close to perfect as possible.

Mr. MOODY. Mr. Herman, do you want to comment on that?

Mr. HERMAN. Yes. Congressman Moody, there is definitely a correlation provable between malpractice incidents, or negligent medical practice and competency. In Florida, from 1975 to 1984, 3 percent of the physicians accounted for 45 percent of the claims. Second, in academic——

Mr. MOODY. Excuse me, you need to control that for specialty, right?

Mr. HERMAN. Yes, and they have those statistics reported.

Mr. MOODY. They would not be as dramatic, I assume, if you just isolated specialty-by-specialty? We all know that——

Mr. HERMAN. That is correct.

Mr. MOODY [continuing]. OB/GYN has a big, high claim even though—as someone said earlier, competent doctors get sued for malpractice suits?

Mr. HERMAN. Absolutely correct. These are geographic and generic rather than specialty-specific. You are quite correct. The Florida Academic Task Force, 1975–1986 found 4 percent responsible for 42 percent of the claims. Illinois a 1987 study, 2 percent of all physicians in Cook County, the GAO's county of study by example, were defendants in 36 percent of the claims. In Pennsylvania, another study in 1985, 1 percent of the physicians——

Mr. MOODY. So you are inferring, if I follow you, that one can statistically infer that if such a small fraction of doctors could generate so many of the claims there must be a competence issue here?

Mr. HERMAN. Right, and let me then say to you why I believe it continues.

We know and every panelist and indeed, the GAO, has cited the Harvard study, published in 1989 based on a 1984 survey of some hospital records: 36,000 negligent incidents or acts. In that year, less than 10 complaints made by the combined State medical societies, in all of New York, as regards competency. Now, you may draw from those statistics a number of conclusions, but when you do not report, and you are not allowed to report, and you are made to feel embarrassed if you report a lack of physician competency within the profession, you not only create the veil of secrecy, you perpetuate it.

I report to you again, the Journal of the American Medical Association—my fellow panelists' own journal on May 26, 1989, reported a study in which 40 percent of the physicians in a controlled experiment said that they would not tell the truth in order to cover up medical negligence in a hospital environment. I have read that study and I believe it involves senior medical students or residents, but that is an astounding figure. Now, I do not blame these 40 percent. There has got to be something wrong with a medical environment that encourages secrecy, that encourages coverup.

Last, I do not believe Americans are stupid, I just do not believe it. My grandmother only went to the sixth grade but she was a wonderful person, and very bright, and she could out-scrabble anybody in the room, and she sat on juries and she was a patient most of her life, and she belonged to AARP and I want to tell you what, you give her her medical record, and she will find a way to understand it.

Mr. MOODY. So you are responding to Dr. Todd's point, that if you give a patient a record, he or she might not be able to understand it?

Mr. HERMAN. They will find a way to understand it. We are not that dumb.

Mr. MOODY. Let me ask, Dr. Todd.

Dr. Todd, is that not the presumption is that the patient, if he or she cannot personally understand they could turn to someone who could give advice to explain it?

Dr. TODD. Well, also Congressman Moody, you have to realize that a lot of things go into medical records, other than the things that Mr. Herman is talking about. And there is a great deal of confidential information that transpires between a patient and a physician——

Mr. MOODY. But this is to the patient—if you transfer that to the patient you are not breaking confidentiality?

Dr. TODD. Well, once the record is public, the damage that can be done to patients because of some of the information that are in those records, having to do with discrimination, the ability for occupations——

Mr. MOODY. But is that not the patient's option? If the patient does not want to make it public, he or she does not have to?

Dr. TODD. Well, so far the patients have not—we do not see any——

Mr. MOODY. I am not saying publish this in the newspaper, I am saying if the patient wants the records leading up to a bad event or might bear on a bad event?

Dr. TODD. They can get them, they are available. Mr. Herman gets them all the time.

Mr. MOODY. Well, in discovery proceedings he can get them, but can the patient get them short of discovery proceedings in a court of law?

Mr. HERMAN. Congressman Moody, in those States, you cannot even get them into the discovery proceeding because the State medical societies and the AMA have special laws which will not allow incident reports, infectious disease reports, or peer review reports to be made public.

As a matter of fact——

Mr. MOODY. Not public but to the patient. That is not the same as public, is it?

Mr. HERMAN. Not public, to the patient. In other words, the patient in discovery is not allowed to get peer review reports. I can tell you that is the law in most States.

Dr. Todd, is that accurate?

Dr. TODD. Well, first of all, the AMA and State medical societies have no special legislation and no special protection such as Mr. Herman was talking about. Every court in this country has held that a patient's record belongs to the patient. And if the patient asks for the record, and the physician is not willing to give the patient that record, the patient can easily obtain it through a court order. But the record is the property of the patient for the benefit and use of the physician.

Mr. MOODY. OK. Mr. Chairman, I have taken up way too much time, but I hope it has been helpful to all concerned. And I appreciate the patience you have all shown with my questions.

Thank you very much.

Mr. COYNE. Mrs. Johnson.

Mrs. JOHNSON. He did clear up this issue of who has access to the patient's medical record. And clearly the patient has access to their own medical record.

As to what access the patient has to the hospital investigations and the hospital records, at what point the patient has access seems to be a point of contention.

I do just want to make the point, Mr. Herman, in response to your earlier comments, there is no interest in or intent by this committee or by myself to deny people compensation. What you overlook is that most people in America have no access to compensation under our current system. And that is an inequity that we cannot overlook. We are looking to expand access to compensation, and I think the figures and experience clearly indicate that something needs to be done if access is to be available to the majority.

Thank you, Mr. Chairman.

Mr. COYNE. Thank you, and thank the panelists. We appreciate your testimony. Thank you.

[Whereupon, at 1 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS AND THE CONGRESS OF NEUROLOGICAL SURGEONS, PRESENTED BY MERWYN BAGAN, M.D.

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to submit a statement addressing the perennial and serious problem of Medical Professional Liability. I say perennial because I appeared before this subcommittee in 1986 to highlight the problem and offer our considered recommendations for remedies.

I am Merwyn Bagan, M.D., a practicing neurosurgeon from Concord, New Hampshire. I speak for the American Association of Neurological Surgeons and the Congress of Neurological Surgeons, which represent more than 3,200 neurosurgeons in the United States.

The differences between 1986 and 1990 are not particularly striking. The crisis remains and is eating at the very fabric of the medical community. The amount of defensive medicine being practiced remains much too high. Premiums for insurance are astronomical, e.g., a neurosurgeon in Chicago could expect to pay $195,950 for insurance in 1989 while in 1986, the costs were $95,000. The pervasive nature of the liability problem now affects playgrounds, child health clinics, voluntary agencies and indeed lawyers. Numerous bills designed to offer federal solutions remain as "pending." All of the various states continue to consider tort reform in one form or another. The need for action on the part of the central government remains an imperative.

In 1986 I enumerated certain statements and in 1990, I will restate them.

1. Medicine is an imperfect science. To quote Sir William Osler, the practice of medicine is "[t]he practice of an art which consists largely in balancing probabilities". None other than President Bush made note of that fact in a recent speech at Johns Hopkins University when he said, "[w]e've got to remember a simple truth: not every unfortunate medical outcome is the result of poor medicine and you cannot make life risk free."

2. There are legitimate negligence claims for which just compensation should be awarded. A study published by the Harvard Medical Practice Study to the State of New York, reported that as a percentage of hospital discharges the rate of negligence by providers (physicians and hospitals) is 1 percent.

3. There are incompetent physicians who should be disciplined. I am pleased to report progress is being made to identify and sanction the incompetent and rehabilitate the impaired physician. The Health Care Quality Improvement Act of 1986 and the Medicare and Medicaid Patient and Program Protection Act of 1987, put in place the mechanism to identify providers practicing unacceptable medicine. The federal government and individual medical specialties are working together to develop practice guidelines. The profession has greatly refined risk management programs.

4. There is in America, a litigious mentality regarding professional or product liability. This insists upon a risk-free society. As President Bush said in his Hopkins' speech, "no risk means no progress."

5. There are attorneys who will file a case without merit, and as a result the number of frivolous cases remains unacceptably high.

Your subcommittee has had the benefit of the General Accounting Office Reports, that of the Library of Congress, and others such as the recent Harvard study in New York State. Thus, I will not elaborate on the statistics and data. The studies indicate that there is a pressing need for a federal remedy to the Byzantine situation that exists at the present time. It is

clear to us that the emotional and financial costs associated with premiums and defensive medicine are much too great. It seems particularly appropriate to us that at a time when the Congress is enacting payment reforms it should also pass legislation for physician liability reform. Such a statute will complement the costs savings of the Resource Based Relative Value Scale and the Medicare Volume Performance Standards now being developed by the federal government.

Mr. Chairman, before I turn to the specifics of Mrs. Johnson's, M.C., bill, I want to briefly comment on the subjective aspects of the liability crisis. In neurosurgery, we have seen certain patterns developing which are of great concern. Many prospective medical students have declined to enter the field because of the potential of medical liability in later years. Of those who have completed medical school, some talented and bright young men and women are not going into and/or are withdrawing from research at the frontiers of knowledge because of liability fears. It is clear that far too many talented physicians are limiting their practice to avoid "high risk" procedures and patients because of the liability concerns. The litigious mentality of our society has eroded the spirit of American medicine and we believe this is insidious.

Mr. Chairman, the American Association of Neurological Surgeons and the Congress of Neurological Surgeons endorse H.R. 4566 the "Medicare Malpractice Dispute Resolution Act of 1990," introduced by Mrs. Nancy Johnson. We are greatly encouraged by the provisions of the legislation, because it encorporates many of the provisions of legislation previously introduced by Senators Inouye, Hatch and Congressmen Mrazek and Gephardt, which indicates to us a growing consensus in the Congress.

The requirements of the bill which we enthusiastically endorse are as follows:

1. Mandatory binding arbitration is particularly appealing to us. This coupled with the provisions for settlement in nine months and immunity for participating parties from court suits arising from the issue being arbitrated will avoid long drawn-out proceedings and fear of additional litigation.

2. The reform proposals for periodic and structured awards, caps on attorney fees, and a limit on non-economic benefits or punitive damages are concepts that have been part of nearly all tort reform recommendations of organizations and state legislatures. To formalize these at the federal level will be very important.

3. The establishment of a two year limitation period beginning on the date the injured party is first made aware of, or should have been aware an injury resulting from malpractice, allows enough time for an injured party to file an action, yet protects the physician from the threat of a suit many years later.

4. Providing that the arbitration panel may assess a share of the opposing party's coasts of participation against a party if the party acted in bad faith in filing the claim should discourage parties from bringing frivolous claims.

We strongly urge the Committee to move quickly to adopt the Johnson bill. We are prepared to cooperate and assist in all ways possible to assure enactment.

Thank you.

STATEMENT OF LEONARD M. RING AND JAMES SEROTA
AMERICAN BAR ASSOCIATION

Mr. Chairman and members of the Subcommittee.

We appreciate this opportunity to present the views of the American Bar Association on medical professional liability. We are Leonard Ring, Chairman of the Section of Tort and Insurance Practice and James Serota, Chairman of the Insurance Industry Committee of the Section of Antitrust Law.

The ABA recognizes the concerns being expressed about the issue of medical professional liability and is deeply committed to having a legal system in America that is effective and just, one that protects the rights of plaintiffs and defendants.

To that end, the ABA has created three committees and commissions to study medical professional liability, the tort liability system, and the liability insurance system.

The first committee, the ABA Special Committee on Medical Professional Liability, was composed of a balanced group of plaintiffs' lawyers, defense lawyers and representatives of academia and the judiciary. The Committee was chaired by Talbot S. D'Alemberte, then Dean of the Florida State University College of Law. The Committee was charged with studying legislative initiatives in the medical malpractice area and developing ABA policy proposals for the Association's policymakers to consider. In February 1986, the ABA House of Delegates adopted a resolution at the recommendation of the Committee. A copy of that resolution is appended to this statement as Appendix A.

There are several measures in the ABA resolution with which the medical profession should be able to agree. The ABA calls for rigorous enforcement of professional disciplinary code provisions which proscribe lawyers from filing frivolous lawsuits and defenses and for the imposition of sanctions when those provisions are violated. The ABA endorses the call for stronger medical licensing and disciplinary procedures and increased funding for state boards working in those areas. We also endorse efforts to implement effective risk management programs in the delivery of health care services. In the area of punitive damages, we oppose requirements of disclosure of financial worth by a defendant in a tort action unless there is a showing by evidence in the record or proffered by the plaintiff that would provide a legal basis for recovery of punitive damages. As a way of assuring that medical malpractice suits are decided on the basis of an appropriate standard of care and that evidence is considered as clearly as possible, the Association urges trial courts to scrutinize carefully the qualifications of persons presented as experts to assure that only those persons are permitted to testify who, by knowledge, skill, experience, training or education, qualify as experts. Finally, our resolution calls for the further collection and study of data on the cost and causes of professional liability claims.

This action by the House reflects the ABA's recognition that the issue is of vital importance not only to the legal profession but to the medical profession, the insurance industry and, most of all, to the public.

It is, after all, the public's interest that is most at stake in this issue. Everyone has an interest in the quality and costs of health care services. And when any person suffers injury as a result of negligence by health care providers, he or she must have the right to seek recovery for the full measure of those damages. We believe that right is severely threatened by those who call for major changes in this country's tort law system, and particularly by those who propose that limits be placed on the amount of damages persons may seek in compensation for their injuries caused by the negligence, or worse, of health care providers.

We are particularly concerned with proposals to alter the system of medical malpractice to carve out exceptions in the tort law system for one group of potential defendants -- in this case, doctors and other medical professionals. It is the ABA's belief that the rights of injured persons to recover fully for injuries caused by the wrongful acts of others must be protected. We are concerned that those who seek major changes in the way the tort law system deals with cases of medical malpractice show a willingness to trade away the rights of all individuals in the hope of easing a perceived burden on some. No single group in society should receive such special treatment under the law.

Near the end of 1985 the ABA, through its President, appointed an Action Commission to Improve the Tort Liability System. The 14-member Commission was asked to develop specific proposals to improve the tort liability system. The members of the Commission were federal trial and appellate court judges; a state Supreme Court justice; corporate counsel, including those with insurance experience; consumer and civil rights advocates; academicians; and practicing plaintiffs and defense lawyers.

In February 1987, the ABA House of delegates considered the Commission's recommendations and adopted the resolution appended to this statement as Appendix B.

With a possible exception relating to mass torts, the ABA takes the position that these proposals to improve the tort system can and should be implemented by the courts and legislatures at the state, and not the federal level. The ABA resolution makes numerous recommendations addressed to the courts and to the lawyers. These recommendations include the following:

1. No ceilings should be placed on pain and suffering awards. Instead, trial and appellate courts should more effectively control pain and suffering verdicts which are either so excessive or so inadequate as to be disproportionate to the injury suffered or to community expectations.

2. Tort awards for pain and suffering should be more uniform. To achieve that goal, the ABA recommends such approaches as objective annual studies of tort awards, public information on those awards, guidelines for use by the trial courts and study given as to whether additional guidance can and should be given to the jury on the range of appropriate damage awards.

3. As far as fee arrangements go, the ABA believes they should be written in plain English or appropriate other language, that percentage fees should be out of the net amount and not out of the gross amount of any judgment or settlement, and that the courts or a public body should disallow lawyers' fees that are found to be plainly excessive.

4. To protect future claimants, the ABA opposes various forms of secrecy agreements and arrangements that require destruction of information or records as well as agreements that would prohibit a particular attorney from representing other claimants.

5. The ABA has specific recommendations addressed to the courts to streamline the litigation process, to eliminate frivolous claims and to reduce the long delays currently characteristic of much litigation. These include permitting non-unanimous jury verdicts and use of alternative dispute resolution methods.

There are certain areas in which the ABA believes state legislative action may be needed.

1. The ABA believes that punitive damages are appropriate in certain cases, but their scope should be limited. They should not be commonplace. The basic standard to establish punitive damages should be a conscious or deliberate disregard of a defendant's obligations. The standard of proof should be "clear and convincing" evidence and not a lesser standard such as "a preponderance of the evidence".

2. The ABA is concerned that no defendant should be subjected to punitive damages that are excessive in the aggregate for the same wrongful act. There should therefore be safeguards to prevent the imposition of repeated punitive damages. The purpose of punitive damages is to punish, not to confiscate. The ABA recognizes that the principal responsibility to control excessive awards for punitive damages rests on the courts; however, state legislation may be necessary to assure more effective judicial review of punitive damage awards.

3. The ABA believes that the doctrine of joint and several liability should be limited by legislation to apply only to economic losses in certain cases. Defendants should not be held liable for someone else's share of any non-economic loss when the defendant's responsibility is substantially disproportionate to liability for the entire loss suffered by the plaintiff.

4. The ABA recognizes that allowing non-unanimous jury verdicts may require legislation.

A number of states enacted tort reform legislation over the past several years. Some of those bills are quite far-ranging, others fairly limited. We do believe that state legislatures should review their tort system and the ABA welcomes the opportunity to further that process.

In 1987 the ABA, through its President, appointed a broadly-based Commission to study and to report and make recommendations to our House of Delegates regarding the liability insurance system.

In response to the ABA Commission report, in February 1989 the American Bar Association's House of Delegates adopted a resolution containing the following two major recommendations:

I. The current McCarran-Ferguson exemption to the antitrust laws should be repealed and replaced with legislation containing the following features:

   (1) Insurers should be made subject to general antitrust laws but provided with authorization to engage in specified cooperative activity that is shown to not unreasonably restrain competition in the industry.

   (2) Insurers should be authorized to cooperate in the collection and dissemination of past loss experience data so long as those activities do not unreasonably restrain competition but should not be authorized to cooperate in the construction of advisory rates or the projection of loss experience into the future in such a manner as to interfere with competitive pricing.

(3) Insurers should be authorized to cooperate to develop standardized policy forms in order to simplify consumer understanding, enhance price competition and support data collection efforts, but state regulators should be given authority to guard against the use of standardized forms to unreasonably limit choices available in the market.

(4) Insurers should be authorized to participate in voluntary joint underwriting agreements and in connection with such agreements to cooperate with each other in making rates, policy forms, and other essential insurance functions so long as those activities do not unreasonably restrain competition.

(5) Insurers participating in residual market mechanisms should be authorized in connection with such activity to cooperate in making rates, policy forms, and other essential insurance functions so long as the residual market mechanism is approved by and subject to the active supervision of a state regulatory agency.

(6) Insurers should be authorized to engage in such other collective activities that Congress specifically finds do not unreasonably restrain competition in insurance markets.

(7) State regulation of insurance rates should not exempt insurers from the antitrust laws under the state action doctrine, except as specified in Recommendation (1) to (6). Other non-rate regulation by a state should not exempt insurers from the antitrust laws unless that regulation satisfies the requirements of the state action doctrine and the regulation is shown to not unreasonably restrain competition.

II. States should retain the authority to regulate the business of insurance. The federal government should defer to state regulation except in those unusual circumstances where the regulatory objective can only be effectively accomplished through federal involvement.

In adopting these two recommendations, the ABA's House of Delegates was aware of the ABA Commission's finding that the effect of the McCarran-Ferguson exemption on insurance pricing and industry practices varies with the underlying state regulatory environment. Replacement of the McCarran-Ferguson exemption with legislation consistent with the ABA's recommendations may increase the competitive atmosphere of the industry and replace the uncertainty concerning the scope and meaning of the existing exemption. Although repeal would create some uncertainty, there is also uncertainty concerning the scope and meaning of the existing exemption. The existing exemption has a substantial impact on the perceptions of the industry and its critics, and unless the issue is resolved it may continue to distract policymakers from more central questions of insurance reform.

Throughout its report, the ABA Commission recommends enhancing competitive market forces as a means of improving the insurance industry. The continued existence of McCarran-Ferguson is inconsistent with that objective. The perception is widely held that McCarran-Ferguson permits insurers to manipulate the insurance mechanism and the price of insurance coverage collusively. Clearly, the industry believes the exemption permits cooperative activity that otherwise could raise serious antitrust concerns. These perceptions impeded consideration of other proposals which may hold greater promise of moderating availability and affordability problems.

The repeal of McCarran-Ferguson has become a symbol in the debate over causes of dislocations in private insurance markets. The ABA Commission did not believe repeal should be regarded as alone sufficient to improve the insurance system or to avoid future dislocations. The scope of the current exemption from antitrust enforcement is quite narow, and boycotts remain subject to antitrust laws. Much of the current concerted activity by insurers is arguably permitted even under the antitrust laws as long as it does not restrain trade. Accordingly, the ABA believes that, in general, the insurance industry should be subject to normal antitrust doctrine, although safe harbors should be specifically provided for cooperative behavior which clearly has legitimate procompetitive consequences.

McCarran-Ferguson is a powerful symbol of the primacy of state regulation of insurance. However, there is nothing in repeal of the exemption that necessitates elevating federal authority beyond application of antitrust laws. The ABA's second major recommendation emphasizes that, notwithstanding its recommendations regarding repeal of McCarran-Ferguson, state regulatory authority should be retained. Congress should not preempt current state regulatory regimes with federal regulation directed at the business of insurance. The tradition of state regulation, the long-standing experience shared by state insurance agencies, and the adjustment of the industry to state regulatory requirements should not be discarded lightly.

At the same time, the repeal of McCarran-Ferguson will intensify the need for independent and adequately funded state insurance agencies. Agencies could enhance the appearance of their independence and their access to broader perspectives if they would formalize the role of consumers in the regulatory process by the appointment of a consumer advocate.

Thank you for giving us this opportunity to present our views to you.

APPENDIX A

RESOLUTION APPROVED BY THE
AMERICAN BAR ASSOCIATION
HOUSE OF DELEGATES

FEBRUARY 11, 1986

BE IT RESOLVED,

1. The American Bar Association urges appropriate ABA entities, such as the Action Commission to Improve the Tort Liability System and the Commission on Professionalism, to continue to consult, where appropriate, with representatives of the American Medical Association and others in the health care industry, the insurance industry, state and federal governments and appropriate segments of the public with the goal of seeking a broader consensus on how more equitably to compensate persons injured in our society. The problems associated with medical professional liability are common to all areas of tort law and should be evaluated in the context of their broader implications for the tort system as a whole. The Legal and Medical professions should cooperate in seeking common solutions to these problems and should avoid any efforts to polarize the discussion of these problems, which would serve neither the public interest nor the interests of either profession.

2. Consistent with these goals, the American Bar Association adopts the following principles:

A. The regulation of medical professional liability is a matter for state consideration; and federal involvement in that area is inappropriate.

B. There should be rigorous enforcement of professional disciplinary code provisions which proscribe lawyers from filing frivolous suits and defenses; and sanctions should be imposed when those provisions are violated.

C. There should be more effective procedures and increased funding to strengthen medical licensing and disciplinary boards at the state level; and efforts should be increased to establish effective risk management programs in the delivery of health care services.

D. No justification exists for exempting medical malpractice actions from the rules of punitive damages applied in tort litigation to deter gross misconduct.

E. No disclosure of financial worth by a defendant in a tort action should be required unless there is a showing by evidence in the record or proffered by the plaintiff that would provide a legal basis for recovery of punitive damages.

F. Notices of intent to sue, screening panels and affidavits of non-involvement are unnecessary in medical malpractice actions.

G. No justification exists for a special rule governing malicious prosecution actions brought by health care providers against persons who sued them for malpractice.

H. Trial courts should scrutinize carefully the qualifications of persons presented as experts to assure that only those persons are permitted to testify who, by knowledge, skill, experience, training or education, qualify as experts.

I. The collateral source rule should be retained; and third parties who have furnished monetary benefits to plaintiffs should be permitted to seek reimbursement out of the recovery.

J. Contingent fees provide access to the courts; and no justification exists for imposing special restrictions on contingent fees in medical malpractice actions.

K. The use of structured settlements should be encouraged.

L. Collection and study of data on the cost and causes of professional liability claims should be undertaken to evaluate and develop effective loss prevention programs.

APPENDIX B

RESOLUTION APPROVED BY THE AMERICAN BAR ASSOCIATION HOUSE OF DELEGATES

February 16-17, 1987
(Report No. 123)

Be It Resolved, That the American Bar Association adopts the following recommendations:

A. Insurance

1. The American Bar Association should establish a commission to study and recommend ways to improve the liability insurance system as it affects the tort system.

B. Pain and Suffering Damages

2. There should be no ceilings on pain and suffering damages, but instead trial and appellate courts should make greater use of the power of remittitur or additur with reference to verdicts which are either so excessive or inadequate as to be clearly disproportionate to community expectations by setting aside such verdicts unless the affected parties agree to the modification.

3. One or more tort award commissions should be established, which would be empowered to review tort awards during the preceding year, publish information on trends, and suggest guidelines for future trial court reference.

4. Options should be explored by appropriate ABA entities whether additional guidance can and should be given to the jury on the range of damages to be awarded for pain and suffering in a particular case.

C. Punitive Damages

5. Punitive damages have a place in appropriate cases and therefore should not be abolished. However, the scope of punitive damages should be narrowed through the following measures:

a. Standards of Conduct and Proof

Punitive damages should be limited to cases warranting special sanctions and should not be commonplace. A threshold requirement for the submission of a punitive damages case to the finder of fact should be that the defendant demonstrated a conscious or deliberate disregard with respect to the plaintiff. As a further safeguard, the standard of proof to be applied should be "clear and convincing" evidence as opposed to any lesser standard such as "by a preponderance of the evidence."

b. The Process of Decision

(1) Pre-Trial - Appropriate pre-trial procedures should be routinely utilized to eliminate frivolous claims for punitive damages prior to trial, with a savings mechanism available for late discovery of misconduct meeting the standard of liability.

(2) Trial - Evidence of net worth and other evidence relevant only to the question of punitive damages ordinarily should be introduced only after the defendant's liability for compensatory damages and the amount of those damages have been determined.

(3) Post-Trial - As a check against excessive punitive damage awards, verdicts including such awards should be subjected to close scrutiny by the courts. The trial court should order remittitur wherever justified. Excessiveness should be evaluated in light of the degree of reprehensibility of the defendant's acts, the risk undertaken by the plaintiff, the actual injury caused, the net worth of the defendant, whether the defendant has reformed its conduct and the degree of departure from typical ratios (as reflected in the best available empirical data) between compensatory and punitive damages. If necessary to assure such judicial review, appropriate legislation should be enacted. Opinions issued by trial or appellate courts either upholding or modifying an award should specify the factors which were considered and relied upon.

c. Multiple Judgment Torts

While the total amount of any punitive damages awarded should be adequate to accomplish the purposes of punitive damages, appropriate safeguards should be put in force to prevent any defendant from being subjected to punitive damages that are excessive in the aggregate for the same wrongful act.

d. Vicarious Liability

With respect to vicarious liability for punitive damages, the provisions of Section 909 of the Restatement (Second) of Torts (1979) should apply. Legislatures and courts should be sensitive to adopting appropriate safeguards to protect the master or principal from vicarious liability for the unauthorized acts of nonmanagerial servants or agents.

e. To Whom Awards Should Be Paid

In certain punitive damages cases, such as torts involving possible multiple judgments against the same defendant, a court could be authorized to determine what is a reasonable portion of the punitive damages award to compensate the plaintiff and counsel for bringing the action and prosecuting the punitive damage claim, with the balance of the award to be allocated to public purposes, which could involve methods of dealing with multiple tort claims such as consolidation of claims or forms of class actions. The novelty of such proposals and the absence of any adequately tested programs for implementing require further study before an informed judgment can be made as to whether, or to what extent, such proposals will work in practice. We urge such studies. The concept of public allocation of portions of punitive damage awards in single judgment actions is also worthy of consideration to the extent workable methods of implementation may hereafter be developed.

D. Joint-and-Several Liability

6. The doctrine of joint-and-several liability should be modified to recognize that defendants whose responsibility is substantially disproportionate to liability for the entire loss suffered by the plaintiff are to be held liable for only their equitable share of the plaintiff's noneconomic loss, while remaining liable for the plaintiff's full economic loss. A defendant's responsibility should be regarded as "substantially disproportionate" when it is significantly less than any of the other defendants; for example, when one of two defendants is determined to be less than 25% responsible for the plaintiff's injury.

E. Attorneys' Fees

7. Fee arrangements with each party in tort cases should be set forth in a written agreement that clearly identifies the basis on which the fee is to be calculated. In addition, because many plaintiffs may not be familiar with the various ways that contingency fees may be calculated, there should be a requirement that the contingency fee information form be given to each plaintiff before a contingency fee agreement is signed. The content of the information form should be specified in each jurisdiction and should include at least the maximum fee percentage, if any, in the jurisdiction, the option of using different fee percentages depending on the amount of work the attorney has done in obtaining a recovery, and the option of using fee percentages that decrease as the size of a recovery increases. The form should be written in plain English, and, where appropriate, other languages.

8. Courts should discourage the practice of taking a percentage fee out of the gross amount of any judgment or settlement. Contingent fees should normally be based only on the net amount recovered after litigation disbursements such as filing fees, deposition costs, trial transcripts, travel, expert witness fees, and other expenses necessary to conduct the litigation.

9. Upon complaint of a person who has retained counsel, or who is required to pay counsel fees, the fee arrangement and the fee amount billed may be submitted to the court or other appropriate public body, which should have the authority to disallow, after a hearing, any portion of a fee found to be "plainly excessive" in light of prevailing rates and practices.

F. Secrecy and Coercive Agreements

10. Where information obtained under secrecy agreements (a) indicates risk of hazards to other persons, or (b) reveals evidence relevant to claims based on such hazards, courts should ordinarily permit disclosure of such information, after hearing, to other plaintiffs or to government agencies who agree to be bound by appropriate agreements or court orders to protect the confidentiality of trade secrets and sensitive proprietary information.

11. No protective order should contain any provision that requires an attorney for a plaintiff in a tort action to destroy information or records furnished pursuant to such order, including the attorney's notes and other work product, unless the attorney for a plaintiff refuses to agree to be bound by the order after the case has been concluded. An attorney for plaintiff should only be required to return copies of documents obtained from the defendant on condition that defendant agrees not to destroy any such documents so that they will be available, under appropriate circumstances, to government agencies or to other litigants in future cases.

12. Any provision in a settlement or other agreement that prohibits an attorney from representing any other claimant in a similar action against the defendant should be void and of no effect. An attorney should not be permitted to sign such an agreement or request another attorney to do so.

G. Streamlining the Litigation Process: Frivolous Claims and Unnecessary Delay

13. A "fast track" system should be adopted for the trial of tort cases. In recommending such a system, we endorse a policy of active judicial management of the pre-trial phases of tort litigation. We anticipate a system that sets up a rigorous pre-trial schedule with a series of deadlines intended to ensure that tort cases are ready to be placed on the trial calendar within a specified time after filing and tried promptly thereafter. The courts should enforce a firm policy against continuances.

14. Steps should be taken by the courts of the various states to adopt procedures for the control and limitation of the scope and duration of discovery in tort cases. The courts should consider, among other initiatives:

(a) At an early scheduling conference, limiting the number of interrogatories any party may serve, and establishing the number and time of depositions according to a firm schedule. Additional discovery could be allowed upon a showing of good cause.

(b) When appropriate, sanctioning attorneys and other persons for abuse of discovery procedures.

15. Standards should be adopted substantially similar to those set forth in Rule 11 of the Federal Rules of Civil Procedure as a means of discouraging dilatory motions practice and frivolous claims and defenses.

16. Trial judges should carefully examine, on a case-by-case basis, whether liability and damage issues can or should be tried separately.

17. Nonunanimous jury verdicts should be permitted in tort cases, such as verdicts by five of six or ten of twelve jurors.

18. Use of the various alternative dispute resolution mechanisms should be encouraged by federal and state legislatures, by federal and state courts, and by all parties who are likely to, or do become involved in tort disputes with others.

H. Injury Prevention/Reduction

19. Attention should be paid to the disciplining of all licensed professionals through the following measures:

(a) A commitment to impose discipline, where warranted, and funding of full-time staff for disciplinary authorities. Discipline of lawyers should continue to be the responsibility of the highest judicial authority in each state in order to safeguard the rights of all citizens.

(b) In every case in which a claim of negligence or other wrongful conduct is made against a licensed professional, relating to his or her profession, and a judgment for the plaintiff is entered or a settlement paid to an injured person, the insurance carrier, or in the absence of a carrier, the plaintiff's attorney, should report the fact and the amount of payment to the licensing authority. Any agreement to withhold such information and/or to close the files from the disciplinary authorities should be unenforceable as contrary to public policy.

I. Mass Tort

20. The American Bar Association should establish a commission as soon as feasible, including members with expertise in tort law, insurance, environmental policy, civil procedure, and regulatory design, to undertake a comprehensive study of the mass tort problem with the goal of offering a set of concrete proposals for dealing in a fair and efficient manner with these cases.

J. Concluding Recommendation

21. After publication of the report, the ABA Action Commission to Improve the Tort Liability System should be discharged of its assignment.

STATEMENT OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE

The American Society of Internal Medicine (ASIM) welcomes the opportunity to submit its written comments for the April 26, 1990, hearing of the Subcommittee on Health, Committee on Ways and Means, regarding issues related to medical malpractice. ASIM is one of the largest medical specialty societies in the country, representing more than 20,000 internists and subspecialists of internal medicine. Internists and internal medicine subspecialists and their patients are being adversely affected by the professional liability insurance problem.

Effect on Internists and Their Patients

1. Access to and Availability of Quality Care. Internists and subspecialists of internal medicine, such as gastroenterologists, whose practices involve invasive procedures are now experiencing significant liability premium increases even though the volume of procedures they perform may be low. This has caused some internists to discontinue these procedures rather than pay the higher liability premium. Further, other specialists and consultants (e.g. obstetricians and orthopedists) have been forced out of practice (or forced to curtail certain activities) in some states because of a lack of affordable professional liability insurance, increasing the burden upon internists and other physicians who continue in practice and whose patients may need access to those specialists.

2. High Overhead Costs. Escalating premiums have added to overhead costs at a time when internists are being asked to hold the line on fees through various cost containment programs initiated by the federal government and the private sector. While most internists currently do not have problems of the same magnitude as other higher risk specialists, in some states, the premiums are now substantial and rising.

3. Doctor - Patient Relationship. The fear of a malpractice claim is adversely affecting the doctor -- patient relationship. Although many experts believe that a good doctor -- patient relationship will lead to fewer suits, the fear of a malpractice claim is causing some internists to maintain a more businesslike, "arms length" relationship with patients. No matter how good the rapport is between a patient and doctor, paranoia about malpractice and the fear of a lawsuit, especially for those who have been sued at least once, is affecting doctors' behavior around their patients.

4. Effect on Physicians' Personal Lives. Medical liability lawsuits (especially when they are frivolous lawsuits) are affecting internists from a personal standpoint, disrupting their personal and professional lives, thereby adversely affecting their ability and in some cases, their commitment to deliver quality care.

5. Defensive Medicine. The current tort system forces internists to practice "defensive medicine" and order additional and sometimes unnecessary tests in anticipation of a medical malpractice lawsuit thereby driving up the cost of health care. Indeed, the cost of defensive medicine (the ordering of additional tests fearing a medical malpractice lawsuit) may have more of an impact on health care costs than professional liability insurance premiums. Surveys have shown that internists are keeping more detailed records, ordering more tests, obtaining more consultations, and are referring patients to other specialists more frequently than in the past. These additional tests at times increase the risk to patients.

6. Injured Patients Must Deal with a Time-consuming, Inefficient and Unpredictable Legal System. Patients who are injured in the course of their treatment deserve to be compensated promptly and fairly. The current legal system does not permit prompt resolution of claims. Medical malpractice cases often take years to resolve. Further, it is estimated that as little as one-fourth to one-third of the total dollars paid in medical professional liability insurance premiums will ultimately be paid to injured patients. Moreover, the handling of medical malpractice cases has developed into a "lottery" system, making it difficult to predict the outcome of these cases. Some cases have resulted in unusually high awards or settlements despite the fact that the physician was clearly not at fault. In other cases, deserving patients have been denied proper compensation.

Ways To Improve the Medical Malpractice System.

Studies have shown that certain tort reforms, when carefully drafted, could help reduce medical liability claim costs and this, in turn, would benefit patients by lowering the costs of delivering health care services. ASIM supports tort reform that accomplishes the following:

1. Limits awards for non-economic damages,

2. Eliminates punitive damages,

3. Eliminates the collateral source rule (eliminates double compensation to plaintiffs for certain items),

4. Allows for periodic payment of future damages and structured settlements,

5. Limits attorneys' fees to reasonable amounts in personal injury and medical malpractice cases,

The rate of premium increases has been much lower in those states that have enacted these or similar reforms than in other states. Clearly, the medical professional liability problem varies significantly from state to state, suggesting that individual states are in the best position to determine the need for legislative relief. However, certain states, many of which have serious medical liability problems, have failed to adopt effective reforms despite diligent efforts by concerned groups. Naturally, this suggests that a "federal solution" or an alternative to the traditional system of handling medical malpractice claims should be considered. In view of this, ASIM strongly supports the notion that any federal initiative that incorporates the reforms listed above should not disrupt already-established, effective tort reforms.

In addition, ASIM supports and encourages the use of studies and demonstration projects to determine if medical malpractice claims could be handled outside the traditional tort system and result in prompt resolution of claims and fair compensation to deserving claimants. The AMA/Specialty Society Medical Liability Project has developed a proposed administrative fault -- based system for handling medical liability claims. Similar alternatives have been proposed by other groups. A long -- term solution to the problem should include consideration of these alternatives. Many of these proposals have merit, but represent such a significant departure from the current system that it would only be prudent to test and evaluate their effectiveness before implementing any one of them on a wide scale basis. ASIM would be pleased to work with the Subcommittee in its consideration of how to improve the medical malpractice system.

FAMILY ORTHOPEDIC ASSOCIATES

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April 6, 1990

Robert J. Leonard
Chief Counsel
Committee on Ways and Means
U. S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Leonard:

With respect to the Press Release #25 from the Honorable Pete Stark, I would like to make the following statement:

Mr. Stark states in his press release that "the current malpractice system serves no one. The system costs too much, leaves some injured patients with no compensation, and fails to provide effective incentives to reduce the number of medical injuries." I take issue at Mr. Stark's statement in that the system does serve one segment of the population, namely the legal profession. It is quite true that no one else is served by the current malpractice system. Statistics of course reveal that approximately 70% of the malpractice dollar goes to the legal system in investigation and prosecuting malpractice lawsuits. For your information, PICOM which is a physicians owned mutual insurance company in the State of Michigan sold its stock approximately 10 years ago for 75¢ a share and that stock now commands a price of $6.00 a share. I think this is indicative that the insurance company certainly is financially well off and in no way is "going under", so to speak.

Approximately 10 years ago when I started practice as an orthopedic surgeon in Flint, Michigan my insurance rates were approximately $8,000.00 a year for $200,000.00 policy coverage with a $600,000.00 aggregate. This last year my policy cost was $45,700.00 for the same coverage. I must state that this coverage is the least expensive of any insurance in the State of Michigan for my specialty. We have been promised by PICOM that we will have a rate increase next year as well. So, I think it behooves any investor interested to buy PICOM stock. I say this with tongue in cheek.

TO: Robert J. Leonard, U. S. House of Representatives

We have a five physician group in our orthoppdic practice that spends almost a quarter of a million dollars a year in malpractice premiums. In 10 years we have had 2 judgements against us that have totaled approximately $5,000.00 paid out by the insurance company on our behalf to the patient. We have had approximately 14 or 15 lawsuits against us and the average cost for defending us has run between $10,000.00 and $17,000.00 per malpractice case. As a group, we have had 3 cases go to trial and in each case the verdict was rendered by jury in favor of the defendent doctor. All other cases were dismissed after the discovery process.

Needless to say, I believe that $250,000.00 per year could easily be better spent or returned to the government to subsidize the Medicare, Medicaid system and I think that would be much more worthwhile than seeing it spent the way it is at this time. I can say that just from my perspective as an orthopedic surgeon. Another option would be that we could reduce our operating costs and subsequently pass those savings onto the health care system. Myself as well as many of my colleagues would be more than happy to do that.

There is no question that this current malpractice system is an abomination. It does make individual physicians gun shy, so to speak, and over test patients and practice expensive defensive medicine.

As an addendum, I would also like to add that all of the quality review methodology that has been implemented by the government to date has not resulted in diminishing the cost of medical care in this country. I sincerely agree that quality peer review, etc. is imperative, but I think the mounds of paperwork that are required in this day and age only adds to society's health care bill. It certainly increases inefficiency in the system and expense and is in addition a factor with the malpractice situation that hurts the Medicare and Medicaid systems.

I would be more than happy to testify at your hearing, not as some professor at some ivory towered institution, but rather as an individual physician in the trenches, so to speak. The picture that I have is crystal clear of the situation.

Sincerely yours,

Larry L. Pack, M.D.
Orthopedic Surgeon

LLP:bms

cc to Mr. Peter Levine, Genesee County Medical Society.